H.L.C.

.....

(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.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

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

(a) SHORT TITLE.—This Act may be cited as the ''America's Affordable Health Choices Act of 2009''.

(b) TABLE OF DIVISIONS, TITLES, AND SUBTITLES.—This Act is divided into divisions, titles, and subtitles as follows:

DIVISION A—AFFORDABLE HEALTH CARE CHOICES

TITLE I—PROTECTIONS AND STANDARDS FOR QUALIFIED HEALTH BENEFITS PLANS

Subtitle A—General Standards

Subtitle B—Standards Guaranteeing Access to Affordable Coverage

Subtitle C—Standards Guaranteeing Access to Essential Benefits

Subtitle D—Additional Consumer Protections

Subtitle E—Governance

Subtitle F—Relation to Other Requirements; Miscellaneous

Subtitle G—Early Investments

TITLE II—HEALTH INSURANCE EXCHANGE AND RELATED PROVISIONS

Subtitle A—Health Insurance Exchange

Subtitle B—Public Health Insurance Option

Subtitle C—Individual Affordability Credits

TITLE III—SHARED RESPONSIBILITY

Subtitle A—Individual Responsibility

Subtitle B—Employer Responsibility

TITLE IV—AMENDMENTS TO INTERNAL REVENUE CODE OF 1986

Subtitle A—Shared Responsibility

Subtitle B—Credit for Small Business Employee Health Coverage Expenses

Subtitle C—Disclosures to Carry Out Health Insurance Exchange Subsidies

Subtitle D—Other Revenue Provisions

DIVISION B—MEDICARE AND MEDICAID IMPROVEMENTS

TITLE I—IMPROVING HEALTH CARE VALUE

Subtitle A—Provisions Related to Medicare Part A

Subtitle B—Provisions Related to Part B

Subtitle C—Provisions Related to Medicare Parts A and B

Subtitle D—Medicare Advantage Reforms

Subtitle E—Improvements to Medicare Part D

Subtitle F—Medicare Rural Access Protections

TITLE II—MEDICARE BENEFICIARY IMPROVEMENTS

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

Subtitle B—Reducing Health Disparities

Subtitle C—Miscellaneous Improvements

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

TITLE IV—QUALITY

Subtitle A—Comparative Effectiveness Research

Subtitle B—Nursing Home Transparency

Subtitle C—Quality Measurements

Subtitle D—Physician Payments Sunshine Provision

Subtitle E—Public Reporting on Health Care-Associated Infections

TITLE V—MEDICARE GRADUATE MEDICAL EDUCATION

TITLE VI—PROGRAM INTEGRITY

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

Subtitle B—Enhanced Penalties for Fraud and Abuse

Subtitle C—Enhanced Program and Provider Protections

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

TITLE VII—MEDICAID AND CHIP

Subtitle A—Medicaid and Health Reform

Subtitle B—Prevention

Subtitle C—Access

Subtitle D—Coverage

Subtitle E—Financing

Subtitle F—Waste, Fraud, and Abuse

Subtitle G—Puerto Rico and the Territories

Subtitle H—Miscellaneous

TITLE VIII—REVENUE-RELATED PROVISIONS

TITLE IX—MISCELLANEOUS PROVISIONS

DIVISION C—PUBLIC HEALTH AND WORKFORCE DEVELOPMENT

TITLE I—COMMUNITY HEALTH CENTERS

TITLE II—WORKFORCE

Subtitle A—Primary Care Workforce

Subtitle B—Nursing Workforce

Subtitle C—Public Health Workforce

Subtitle D—Adapting Workforce to Evolving Health System Needs

TITLE III—PREVENTION AND WELLNESS

TITLE IV—QUALITY AND SURVEILLANCE

TITLE V—OTHER PROVISIONS

Subtitle A—Drug Discount for Rural and Other Hospitals

Subtitle B—School-Based Health Clinics

Subtitle C—National Medical Device Registry

Subtitle D—Grants for Comprehensive Programs to Provide Education to Nurses and Create a Pipeline to Nursing

Subtitle E—States Failing to Adhere to Certain Employment Obligations

DIVISION A—AFFORDABLE HEALTH CARE CHOICES

SEC. 100. PURPOSE; TABLE OF CONTENTS OF DIVISION; GENERAL DEFINITIONS.

(a) PURPOSE.—

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

(2) BUILDING ON CURRENT SYSTEM.—This division achieves this purpose by building on what

works in today's health care system, while repairing the aspects that are broken.

(3) INSURANCE REFORMS.—This division—

(A) enacts strong insurance market reforms;

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

(C) includes sliding scale affordability credits; and

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

so that all Americans have coverage of essential health benefits.

(4) HEALTH DELIVERY REFORM.—This division institutes health delivery system reforms both to increase quality and to reduce growth in health spending so that health care becomes more affordable for businesses, families, and government.

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

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

TITLE I—PROTECTIONS AND STANDARDS FOR QUALIFIED HEALTH BENEFITS PLANS

Subtitle A—General Standards

Sec. 101. Requirements reforming health insurance marketplace.
Sec. 102. Protecting the choice to keep current coverage.

Subtitle B—Standards Guaranteeing Access to Affordable Coverage

Sec. 111. Prohibiting pre-existing condition exclusions.
Sec. 112. Guaranteed issue and renewal for insured plans.
Sec. 113. Insurance rating rules.
Sec. 114. Nondiscrimination in benefits; parity in mental health and substance abuse disorder benefits.
Sec. 115. Ensuring adequacy of provider networks.
Sec. 116. Ensuring value and lower premiums.

Subtitle C—Standards Guaranteeing Access to Essential Benefits

Sec. 121. Coverage of essential benefits package.
Sec. 122. Essential benefits package defined.
Sec. 123. Health Benefits Advisory Committee.
Sec. 124. Process for adoption of recommendations; adoption of benefit standards.

Subtitle D—Additional Consumer Protections

Sec. 131. Requiring fair marketing practices by health insurers.
Sec. 132. Requiring fair grievance and appeals mechanisms.
Sec. 133. Requiring information transparency and plan disclosure.
Sec. 134. Application to qualified health benefits plans not offered through the Health Insurance Exchange.
Sec. 135. Timely payment of claims.
Sec. 136. Standardized rules for coordination and subrogation of benefits.
Sec. 137. Application of administrative simplification.

Subtitle E—Governance

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

Subtitle F—Relation to Other Requirements; Miscellaneous

Sec. 151. Relation to other requirements.
Sec. 152. Prohibiting discrimination in health care.
Sec. 153. Whistleblower protection.
Sec. 154. Construction regarding collective bargaining.
Sec. 155. Severability.

Subtitle G—Early Investments

Sec. 161. Ensuring value and lower premiums.
Sec. 162. Ending health insurance rescission abuse.
Sec. 163. Administrative simplification.
Sec. 164. Reinsurance program for retirees.

TITLE II—HEALTH INSURANCE EXCHANGE AND RELATED PROVISIONS

Subtitle A—Health Insurance Exchange

Sec. 201. Establishment of Health Insurance Exchange; outline of duties; definitions.

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

Subtitle B—Public Health Insurance Option

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

Subtitle C—Individual Affordability Credits

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

TITLE III—SHARED RESPONSIBILITY

Subtitle A—Individual Responsibility

Sec. 301. Individual responsibility.

Subtitle B—Employer Responsibility

Part 1—Health Coverage Participation Requirements

Sec. 311. Health coverage participation requirements.
Sec. 312. Employer responsibility to contribute towards employee and dependent coverage.
Sec. 313. Employer contributions in lieu of coverage.
Sec. 314. Authority related to improper steering.

Part 2—Satisfaction of Health Coverage Participation Requirements

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

TITLE IV—AMENDMENTS TO INTERNAL REVENUE CODE OF 1986

Subtitle A—Shared Responsibility

PART 1—INDIVIDUAL RESPONSIBILITY

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

PART 2—EMPLOYER RESPONSIBILITY

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

Subtitle B—Credit for Small Business Employee Health Coverage Expenses

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

Subtitle C—Disclosures to Carry Out Health Insurance Exchange Subsidies

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

Subtitle D—Other Revenue Provisions

PART 1—GENERAL PROVISIONS

Sec. 441. Surcharge on high income individuals.
Sec. 442. Delay in application of worldwide allocation of interest.

PART 2—PREVENTION OF TAX AVOIDANCE

Sec. 451. Limitation on treaty benefits for certain deductible payments.
Sec. 452. Codification of economic substance doctrine.
Sec. 453. Penalties for underpayments.

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

(1) ACCEPTABLE COVERAGE.—The term ''acceptable coverage'' has the meaning given such term in section 202(d)(2).

(2) BASIC PLAN.—The term ''basic plan'' has the meaning given such term in section 203(c).

(3) COMMISSIONER.—The term ''Commissioner'' means the Health Choices Commissioner established under section 141.

(4) COST-SHARING.—The term ''cost-sharing'' includes deductibles, coinsurance, copayments, and

similar charges but does not include premiums or any network payment differential for covered services or spending for non-covered services.

(5) DEPENDENT.—The term ''dependent'' has the meaning given such term by the Commissioner and includes a spouse.

(6) EMPLOYMENT-BASED HEALTH PLAN.—The term ''employment-based health plan''—

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

(B) includes such a plan that is the following:

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

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

(7) ENHANCED PLAN.—The term ''enhanced plan'' has the meaning given such term in section 203(c).

(8) ESSENTIAL BENEFITS PACKAGE.—The term ''essential benefits package'' is defined in section 122(a).

(9) FAMILY.—The term ''family'' means an individual and includes the individual's dependents.

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

(11) HEALTH BENEFITS PLAN.—The terms ''health benefits plan'' means health insurance coverage and an employment-based health plan and includes the public health insurance option.

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

(13) HEALTH INSURANCE EXCHANGE.—The term ''Health Insurance Exchange'' means the

Health Insurance Exchange established under section 201.

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

(15) MEDICARE.—The term ''Medicare'' means the health insurance programs under title XVIII of the Social Security Act.

(16) PLAN SPONSOR.—The term ''plan sponsor'' has the meaning given such term in section 3(16)(B) of the Employee Retirement Income Security Act of 1974.

(17) PLAN YEAR.—The term ''plan year'' means—

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

(B) with respect to a health benefits plan other than an employment-based health plan, a 12-month period as specified by the Commissioner.

(18) PREMIUM PLAN; PREMIUM-PLUS PLAN.—The terms ''premium plan'' and ''premium-plus

plan'' have the meanings given such terms in section 203(c).

(19) QHBP OFFERING ENTITY.—The terms ''QHBP offering entity'' means, with respect to a health benefits plan that is—

(A) a group health plan (as defined, subject to subsection (d), in section 733(a)(1) of the Employee Retirement Income Security Act of 1974), the plan sponsor in relation to such group health plan, except that, in the case of a plan maintained jointly by 1 or more employers and 1 or more employee organizations and with respect to which an employer is the primary source of financing, such term means such employer;

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

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

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

(E) a Federal governmental plan (as defined in section 2791(d) of the Public Health Service Act), the appropriate Federal official.

(20) QUALIFIED HEALTH BENEFITS PLAN.—The term ''qualified health benefits plan'' means a health benefits plan that meets the requirements for such a plan under title I and includes the public health insurance option.

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

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

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

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

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

(23) STATE.—The term ''State'' means the 50 States and the District of Columbia.

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

(25) Y1, Y2, ETC..—The terms ''Y1'' , ''Y2'', ''Y3'', ''Y4'', ''Y5'', and similar subsequently numbered terms, mean 2013 and subsequent years, respectively.

TITLE I—PROTECTIONS AND STANDARDS FOR QUALIFIED HEALTH BENEFITS PLANS

Subtitle A—General Standards

SEC. 101. REQUIREMENTS REFORMING HEALTH INSURANCE MARKETPLACE.

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

(b) REQUIREMENTS FOR QUALIFIED HEALTH BENEFITS PLANS.—On or after the first day of Y1, a health benefits plan shall not be a qualified health benefits plan under this division unless the plan meets the applicable requirements of the following subtitles for the type of plan and plan year involved:

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

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

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

(c) TERMINOLOGY.—In this division:

(1) ENROLLMENT IN EMPLOYMENT-BASED HEALTH PLANS.—An individual shall be treated as being ''enrolled'' in an employment-based health plan if the individual is a participant or beneficiary (as such terms are defined in section 3(7) and 3(8), respectively, of the Employee Retirement Income Security Act of 1974) in such plan.

(2) INDIVIDUAL AND GROUP HEALTH INSURANCE COVERAGE.—The terms ''individual health insurance coverage'' and ''group health insurance coverage'' mean health insurance coverage offered in the individual market or large or small group market, respectively, as defined in section 2791 of the Public Health Service Act.

SEC. 102. PROTECTING THE CHOICE TO KEEP CURRENT COVERAGE.

(a) GRANDFATHERED HEALTH INSURANCE COVERAGE DEFINED.—Subject to the succeeding provisions of this section, for purposes of establishing acceptable coverage under this division, the term ''grandfathered health insurance coverage'' means individual health insurance coverage that is offered and in force and effect before the first day of Y1 if the following conditions are met:

(1) LIMITATION ON NEW ENROLLMENT.—

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

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

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

(3) RESTRICTIONS ON PREMIUM INCREASES.—The issuer cannot vary the percentage increase in the premium for a risk group of enrollees in specific grandfathered health insurance coverage without changing the premium for all enrollees in the same risk group at the same rate, as specified by the Commissioner.

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

(1) GRACE PERIOD.—

(A) IN GENERAL.—The Commissioner shall establish a grace period whereby, for plan years beginning after the end of the 5-year period beginning with Y1, an employment-based health plan in operation as of the day before the first day of Y1 must meet the same requirements as apply to a qualified health benefits plan under section 101, including the essential benefit package requirement under section 121.

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

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

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

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

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

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

(c) LIMITATION ON INDIVIDUAL HEALTH INSURANCE COVERAGE.—

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

(2) SEPARATE, EXCEPTED COVERAGE PERMITTED.—Excepted benefits (as defined in section 2791(c) of the Public Health Service Act) are not included within the definition of health insurance coverage. Nothing in paragraph (1) shall prevent the offering, other than through the Health Insurance Exchange, of excepted benefits so long as it is offered and priced separately from health insurance coverage.

Subtitle B—Standards Guaranteeing Access to Affordable Coverage

SEC. 111. PROHIBITING PRE-EXISTING CONDITION EXCLUSIONS.

A qualified health benefits plan may not impose any pre-existing condition exclusion (as defined in section 2701(b)(1)(A) of the Public Health Service Act) or otherwise impose any limit or condition on the coverage under the plan with respect to an individual or dependent based on any health status-related factors (as defined in section

2791(d)(9) of the Public Health Service Act) in relation to the individual or dependent.

SEC. 112. GUARANTEED ISSUE AND RENEWAL FOR INSURED PLANS.

The requirements of sections 2711 (other than subsections (c) and (e)) and 2712 (other than paragraphs (3), and (6) of subsection (b) and subsection (e)) of the Public Health Service Act, relating to guaranteed availability and renewability of health insurance coverage, shall apply to individuals and employers in all individual and group health insurance coverage, whether offered to individuals or employers through the Health Insurance Exchange, through any employment-based health plan, or otherwise, in the same manner as such sections apply to employers and health insurance coverage offered in the small group market, except that such section 2712(b)(1) shall apply only if, before nonrenewal or discontinuation of coverage, the issuer has provided the enrollee with notice of nonpayment of premiums and there is a grace period during which the enrollees has an opportunity to correct such nonpayment. Rescissions of such coverage shall be prohibited except in cases of fraud as defined in sections 2712(b)(2) of such Act.

SEC. 113. INSURANCE RATING RULES.

(a) IN GENERAL.—The premium rate charged for an insured qualified health benefits plan may not vary except as follows:

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

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

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

(b) STUDY AND REPORTS.—

(1) STUDY.—The Commissioner, in coordination with the Secretary of Health and Human Services and the Secretary of Labor, shall conduct a study of the large group insured and self-insured

employer health care markets. Such study shall examine the following:

(A) The types of employers by key characteristics, including size, that purchase insured products versus those that self-insure.

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

(C) The financial solvency and capital reserve levels of employers that self-insure by employer size.

(D) The risk of self-insured employers not being able to pay obligations or otherwise becoming financially insolvent.

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

(2) REPORTS.—Not later than 18 months after the date of the enactment of this Act, the Commissioner shall submit to Congress and the applicable agencies a report on the study conducted under paragraph (1). Such report shall include any recommendations the Commissioner deems appropriate to ensure that the law does not provide incentives

for small and mid-size employers to self-insure or create adverse selection in the risk pools of large group insurers and self-insured employers. Not later than 18 months after the first day of Y1, the Commissioner shall submit to Congress and the applicable agencies an updated report on such study, including updates on such recommendations.

SEC. 114. NONDISCRIMINATION IN BENEFITS; PARITY IN MENTAL HEALTH AND SUBSTANCE ABUSE DISORDER BENEFITS.

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

(b) PARITY IN MENTAL HEALTH AND SUBSTANCE ABUSE DISORDER BENEFITS.—To the extent such provisions are not superceded by or inconsistent with subtitle C, the provisions of section 2705 (other than subsections (a)(1), (a)(2), and (c)) of section 2705 of the Public Health Service Act shall apply to a qualified health benefits plan, regardless of whether it is offered in the indi-

vidual or group market, in the same manner as such provisions apply to health insurance coverage offered in the large group market.

SEC. 115. ENSURING ADEQUACY OF PROVIDER NETWORKS.

(a) IN GENERAL.—A qualified health benefits plan that uses a provider network for items and services shall meet such standards respecting provider networks as the Commissioner may establish to assure the adequacy of such networks in ensuring enrollee access to such items and services and transparency in the cost-sharing differentials between in-network coverage and out-of-network coverage.

(b) PROVIDER NETWORK DEFINED.—In this division, the term ''provider network'' means the providers with respect to which covered benefits, treatments, and services are available under a health benefits plan.

SEC. 116. ENSURING VALUE AND LOWER PREMIUMS.

(a) IN GENERAL.—A qualified health benefits plan shall meet a medical loss ratio as defined by the Commissioner. For any plan year in which the qualified health benefits plan does not meet such medical loss ratio, QHBP offering entity shall provide in a manner specified by the Commissioner for rebates to enrollees of payment sufficient to meet such loss ratio.

(b) BUILDING ON INTERIM RULES.—In implementing subsection (a), the Commissioner shall build on the definition and methodology developed by the Secretary of Health and Human Services under the amendments made by section 161 for determining how to calculate the medical loss ratio. Such methodology shall be set at the highest level medical loss ratio possible that is designed to ensure adequate participation by QHBP offering entities, competition in the health insurance market in and out of the Health Insurance Exchange, and value for consumers so that their premiums are used for services.

Subtitle C—Standards Guaranteeing Access to Essential Benefits

SEC. 121. COVERAGE OF ESSENTIAL BENEFITS PACKAGE.

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

(b) CHOICE OF COVERAGE.—

(1) NON-EXCHANGE-PARTICIPATING HEALTH BENEFITS PLANS.—In the case of a qualified health benefits plan that is not an Exchange-participating health benefits plan, such plan may offer such cov-

erage in addition to the essential benefits package as the QHBP offering entity may specify.

(2) EXCHANGE-PARTICIPATING HEALTH BENEFITS PLANS.—In the case of an Exchange-participating health benefits plan, such plan is required under section 203 to provide specified levels of benefits and, in the case of a plan offering a premium-plus level of benefits, provide additional benefits.

(3) CONTINUATION OF OFFERING OF SEPARATE EXCEPTED BENEFITS COVERAGE.—Nothing in this division shall be construed as affecting the offering of health benefits in the form of excepted benefits (described in section 102(b)(1)(B)(ii)) if such benefits are offered under a separate policy, contract, or certificate of insurance.

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

SEC. 122. ESSENTIAL BENEFITS PACKAGE DEFINED.

(a) IN GENERAL.—In this division, the term ''essential benefits package'' means health benefits coverage, consistent with standards adopted under section 124 to

ensure the provision of quality health care and financial security, that—

(1) provides payment for the items and services described in subsection (b) in accordance with generally accepted standards of medical or other appropriate clinical or professional practice;

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

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

(4) complies with section 115(a) (relating to network adequacy); and

(5) is equivalent, as certified by Office of the Actuary of the Centers for Medicare & Medicaid Services, to the average prevailing employer-sponsored coverage.

(b) MINIMUM SERVICES TO BE COVERED.—The items and services described in this subsection are the following:

(1) Hospitalization.

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

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

(4) Such services, equipment, and supplies incident to the services of a physician's or a health professional's delivery of care in institutional settings, physician offices, patients' homes or place of residence, or other settings, as appropriate.

(5) Prescription drugs.

(6) Rehabilitative and habilitative services.

(7) Mental health and substance use disorder services.

(8) Preventive services, including those services recommended with a grade of A or B by the Task Force on Clinical Preventive Services and those vaccines recommended for use by the Director of the Centers for Disease Control and Prevention.

(9) Maternity care.

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

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

(1) NO COST-SHARING FOR PREVENTIVE SERVICES.—There shall be no cost-sharing under the essential benefits package for preventive items and

services (as specified under the benefit standards), including well baby and well child care.

(2) ANNUAL LIMITATION.—

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

(B) APPLICABLE LEVEL.—The applicable level specified in this subparagraph for Y1 is $5,000 for an individual and $10,000 for a family. Such levels shall be increased (rounded to the nearest $100) for each subsequent year by the annual percentage increase in the Consumer Price Index (United States city average) applicable to such year.

(C) USE OF COPAYMENTS.—In establishing cost-sharing levels for basic, enhanced, and premium plans under this subsection, the Secretary shall, to the maximum extent possible, use only copayments and not coinsurance.

(3) MINIMUM ACTUARIAL VALUE.—

(A) IN GENERAL.—The cost-sharing under the essential benefits package shall be designed to provide a level of coverage that is designed

to provide benefits that are actuarially equivalent to approximately 70 percent of the full actuarial value of the benefits provided under the reference benefits package described in subparagraph (B).

(B) REFERENCE BENEFITS PACKAGE DESCRIBED.—The reference benefits package described in this subparagraph is the essential benefits package if there were no cost-sharing imposed.

SEC. 123. HEALTH BENEFITS ADVISORY COMMITTEE.

(a) ESTABLISHMENT.—

(1) IN GENERAL.—There is established a private-public advisory committee which shall be a panel of medical and other experts to be known as the Health Benefits Advisory Committee to recommend covered benefits and essential, enhanced, and premium plans.

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

(3) MEMBERSHIP.—The Health Benefits Advisory Committee shall be composed of the following members, in addition to the Surgeon General:

(A) 9 members who are not Federal employees or officers and who are appointed by the President.

(B) 9 members who are not Federal employees or officers and who are appointed by the Comptroller General of the United States in a manner similar to the manner in which the Comptroller General appoints members to the Medicare Payment Advisory Commission under section 1805(c) of the Social Security Act.

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

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

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

(5) PARTICIPATION.—The membership of the Health Benefits Advisory Committee shall at least reflect providers, consumer representatives, employ-

ers, labor, health insurance issuers, experts in health care financing and delivery, experts in racial and ethnic disparities, experts in care for those with disabilities, representatives of relevant governmental agencies. and at least one practicing physician or other health professional and an expert on children's health and shall represent a balance among various sectors of the health care system so that no single sector unduly influences the recommendations of such Committee.

(b) DUTIES.—

(1) RECOMMENDATIONS ON BENEFIT STANDARDS.—The Health Benefits Advisory Committee shall recommend to the Secretary of Health and Human Services (in this subtitle referred to as the ''Secretary'') benefit standards (as defined in paragraph (4)), and periodic updates to such standards. In developing such recommendations, the Committee shall take into account innovation in health care and consider how such standards could reduce health disparities.

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

(3) PUBLIC INPUT.—The Health Benefits Advisory Committee shall allow for public input as a part of developing recommendations under this subsection.

(4) BENEFIT STANDARDS DEFINED.—In this subtitle, the term ''benefit standards'' means standards respecting—

(A) the essential benefits package described in section 122, including categories of covered treatments, items and services within benefit classes, and cost-sharing; and

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

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

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

(B) PREMIUM PLAN.—The level of cost-sharing for premium plans shall be designed so

that such plans have benefits that are actuarially equivalent to approximately 95 percent of the actuarial value of the benefits provided under the reference benefits package described in section 122(c)(3)(B).

(c) OPERATIONS.—

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

(2) MEMBERS NOT TREATED AS FEDERAL EMPLOYEES.—Members of the Health Benefits Advisory Committee shall not be considered employees of the Federal government solely by reason of any service on the Committee.

(3) APPLICATION OF FACA.—The Federal Advisory Committee Act (5 U.S.C. App.), other than section 14, shall apply to the Health Benefits Advisory Committee.

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

Services of all recommendations made by the Health Benefits Advisory Committee under this section.

SEC. 124. PROCESS FOR ADOPTION OF RECOMMENDATIONS; ADOPTION OF BENEFIT STANDARDS.

(a) PROCESS FOR ADOPTION OF RECOMMENDATIONS.—

(1) REVIEW OF RECOMMENDED STANDARDS.—Not later than 45 days after the date of receipt of benefit standards recommended under section 123 (including such standards as modified under paragraph (2)(B)), the Secretary shall review such standards and shall determine whether to propose adoption of such standards as a package.

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

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

(B) not to propose adoption of such standards as a package, the Secretary shall notify the Health Benefits Advisory Committee in writing of such determination and the reasons for not proposing the adoption of such rec-

ommendation and provide the Committee with a further opportunity to modify its previous recommendations and submit new recommendations to the Secretary on a timely basis.

(3) CONTINGENCY.—If, because of the application of paragraph (2)(B), the Secretary would otherwise be unable to propose initial adoption of such recommended standards by the deadline specified in subsection (b)(1), the Secretary shall, by regulation under section 553 of title 5, United States Code, propose adoption of initial benefit standards by such deadline.

(4) PUBLICATION.—The Secretary shall provide for publication in the Federal Register of all determinations made by the Secretary under this subsection.

(b) ADOPTION OF STANDARDS.—

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

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

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

(3) REQUIREMENT.—The Secretary may not adopt any benefit standards for an essential benefits package or for level of cost-sharing that are inconsistent with the requirements for such a package or level under sections 122 and 123(b)(5).

Subtitle D—Additional Consumer Protections

SEC. 131. REQUIRING FAIR MARKETING PRACTICES BY HEALTH INSURERS.

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

SEC. 132. REQUIRING FAIR GRIEVANCE AND APPEALS MECHANISMS.

(a) IN GENERAL.—A QHBP offering entity shall provide for timely grievance and appeals mechanisms that the Commissioner shall establish.

(b) INTERNAL CLAIMS AND APPEALS PROCESS.—Under a qualified health benefits plan the QHBP offering entity shall provide an internal claims and appeals process that initially incorporates the claims and appeals procedures (including urgent claims) set forth at section 2560.503–1 of title 29, Code of Federal Regulations, as

published on November 21, 2000 (65 Fed. Reg. 70246) and shall update such process in accordance with any standards that the Commissioner may establish.

(c) EXTERNAL REVIEW PROCESS.—

(1) IN GENERAL.—The Commissioner shall establish an external review process (including procedures for expedited reviews of urgent claims) that provides for an impartial, independent, and de novo review of denied claims under this division.

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

(d) CONSTRUCTION.—Nothing in this section shall be construed as affecting the availability of judicial review under State law for adverse decisions under subsection (b) or (c), subject to section 151.

SEC. 133. REQUIRING INFORMATION TRANSPARENCY AND PLAN DISCLOSURE.

(a) ACCURATE AND TIMELY DISCLOSURE.—

(1) IN GENERAL.—A qualified health benefits plan shall comply with standards established by the Commissioner for the accurate and timely disclosure

of plan documents, plan terms and conditions, claims payment policies and practices, periodic financial disclosure, data on enrollment, data on disenrollment, data on the number of claims denials, data on rating practices, information on cost-sharing and payments with respect to any out-of-network coverage, and other information as determined appropriate by the Commissioner. The Commissioner shall require that such disclosure be provided in plain language.

(2) PLAIN LANGUAGE.—In this subsection, the term ''plain language'' means language that the intended audience, including individuals with limited English proficiency, can readily understand and use because that language is clean, concise, well-organized, and follows other best practices of plain language writing.

(3) GUIDANCE.—The Commissioner shall develop and issue guidance on best practices of plain language writing.

(b) CONTRACTING REIMBURSEMENT.—A qualified health benefits plan shall comply with standards established by the Commissioner to ensure transparency to each health care provider relating to reimbursement arrangements between such plan and such provider.

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

SEC. 134. APPLICATION TO QUALIFIED HEALTH BENEFITS PLANS NOT OFFERED THROUGH THE HEALTH INSURANCE EXCHANGE.

The requirements of the previous provisions of this subtitle shall apply to qualified health benefits plans that are not being offered through the Health Insurance Exchange only to the extent specified by the Commissioner.

SEC. 135. TIMELY PAYMENT OF CLAIMS.

A QHBP offering entity shall comply with the requirements of section 1857(f) of the Social Security Act with respect to a qualified health benefits plan it offers in the same manner an Medicare Advantage organization is required to comply with such requirements with respect to a Medicare Advantage plan it offers under part C of Medicare.

SEC. 136. STANDARDIZED RULES FOR COORDINATION AND SUBROGATION OF BENEFITS.

The Commissioner shall establish standards for the coordination and subrogation of benefits and reimbursement of payments in cases involving individuals and multiple plan coverage.

SEC. 137. APPLICATION OF ADMINISTRATIVE SIMPLIFICATION.

A QHBP offering entity is required to comply with standards for electronic financial and administrative transactions under section 1173A of the Social Security Act, added by section 163(a).

Subtitle E—Governance

SEC. 141. HEALTH CHOICES ADMINISTRATION; HEALTH CHOICES COMMISSIONER.

(a) IN GENERAL.—There is hereby established, as an independent agency in the executive branch of the Government, a Health Choices Administration (in this division referred to as the ''Administration'').

(b) COMMISSIONER.—

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

(2) COMPENSATION; ETC.—The provisions of paragraphs (2), (5) and (7) of subsection (a) (relating to compensation, terms, general powers, rulemaking, and delegation) of section 702 of the Social Security Act (42 U.S.C. 902) shall apply to the Commissioner and the Administration in the same manner as such provisions apply to the Commis-

sioner of Social Security and the Social Security Administration.

SEC. 142. DUTIES AND AUTHORITY OF COMMISSIONER.

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

(1) QUALIFIED PLAN STANDARDS.—The establishment of qualified health benefits plan standards under this title, including the enforcement of such standards in coordination with State insurance regulators and the Secretaries of Labor and the Treasury.

(2) HEALTH INSURANCE EXCHANGE.—The establishment and operation of a Health Insurance Exchange under subtitle A of title II.

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

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

(b) PROMOTING ACCOUNTABILITY.—

(1) IN GENERAL.—The Commissioner shall undertake activities in accordance with this subtitle to promote accountability of QHBP offering entities in meeting Federal health insurance requirements, re-

gardless of whether such accountability is with respect to qualified health benefits plans offered through the Health Insurance Exchange or outside of such Exchange.

(2) COMPLIANCE EXAMINATION AND AUDITS.—

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

(B) RECOUPMENT OF COSTS IN CONNECTION WITH EXAMINATION AND AUDITS.—The Commissioner is authorized to recoup from qualified health benefits plans reimbursement for the costs of such examinations and audit of such QHBP offering entities.

(c) DATA COLLECTION.—The Commissioner shall collect data for purposes of carrying out the Commissioner's duties, including for purposes of promoting quality and value, protecting consumers, and addressing disparities in health and health care and may share such data with the Secretary of Health and Human Services.

(d) SANCTIONS AUTHORITY.—

(1) IN GENERAL.—In the case that the Commissioner determines that a QHBP offering entity violates a requirement of this title, the Commissioner may, in coordination with State insurance regulators and the Secretary of Labor, provide, in addition to any other remedies authorized by law, for any of the remedies described in paragraph (2).

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

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

(B) suspension of enrollment of individuals under such plan after the date the Commissioner notifies the entity of a determination under paragraph (1) and until the Commissioner is satisfied that the basis for such determination has been corrected and is not likely to recur;

(C) in the case of an Exchange-participating health benefits plan, suspension of payment to the entity under the Health Insurance

Exchange for individuals enrolled in such plan after the date the Commissioner notifies the entity of a determination under paragraph (1) and until the Secretary is satisfied that the basis for such determination has been corrected and is not likely to recur; or

(D) working with State insurance regulators to terminate plans for repeated failure by the offering entity to meet the requirements of this title.

(e) STANDARD DEFINITIONS OF INSURANCE AND MEDICAL TERMS.—The Commissioner shall provide for the development of standards for the definitions of terms used in health insurance coverage, including insurance-related terms.

(f) EFFICIENCY IN ADMINISTRATION.—The Commissioner shall issue regulations for the effective and efficient administration of the Health Insurance Exchange and affordability credits under subtitle C, including, with respect to the determination of eligibility for affordability credits, the use of personnel who are employed in accordance with the requirements of title 5, United States Code, to carry out the duties of the Commissioner or, in the case of sections 208 and 241(b)(2), the use of State personnel who are employed in accordance with standards prescribed by

the Office of Personnel Management pursuant to section 208 of the Intergovernmental Personnel Act of 1970 (42 U.S.C. 4728).

SEC. 143. CONSULTATION AND COORDINATION.

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

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

(2) Appropriate State agencies, specifically concerning the administration of individual affordability credits under subtitle C of title II and the offering of Exchange-participating health benefits plans, to Medicaid eligible individuals under subtitle A of such title.

(3) Other appropriate Federal agencies.

(4) Indian tribes and tribal organizations.

(5) The National Association of Insurance Commissioners for purposes of using model guidelines established by such association for purposes of subtitles B and D.

(b) COORDINATION.—

(1) IN GENERAL.—In carrying out the functions of the Commissioner, including with respect to the enforcement of the provisions of this division, the Commissioner shall work in coordination with existing Federal and State entities to the maximum extent feasible consistent with this division and in a manner that prevents conflicts of interest in duties and ensures effective enforcement.

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

SEC. 144. HEALTH INSURANCE OMBUDSMAN.

(a) IN GENERAL.—The Commissioner shall appoint within the Health Choices Administration a Qualified Health Benefits Plan Ombudsman who shall have expertise and experience in the fields of health care and education of (and assistance to) individuals.

(b) DUTIES.—The Qualified Health Benefits Plan Ombudsman shall, in a linguistically appropriate manner—

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

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

(A) helping individuals determine the relevant information needed to seek an appeal of a decision or determination;

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

(C) assistance to such individuals in choosing a qualified health benefits plan in which to enroll; and

(D) assistance to such individuals in presenting information under subtitle C (relating to affordability credits); and

(3) submit annual reports to Congress and the Commissioner that describe the activities of the Ombudsman and that include such recommendations for improvement in the administration of this division as the Ombudsman determines appropriate. The Ombudsman shall not serve as an advocate for any increases in payments or new coverage of services, but may identify issues and problems in payment or coverage policies.

Subtitle F—Relation to Other Requirements; Miscellaneous

SEC. 151. RELATION TO OTHER REQUIREMENTS.

(a) COVERAGE NOT OFFERED THROUGH EXCHANGE.—

(1) IN GENERAL.—In the case of health insurance coverage not offered through the Health Insurance Exchange (whether or not offered in connection with an employment-based health plan), and in the case of employment-based health plans, the requirements of this title do not supercede any requirements applicable under titles XXII and XXVII of the Public Health Service Act, parts 6 and 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974, or State law, except insofar as such requirements prevent the application of a requirement of this division, as determined by the Commissioner.

(2) CONSTRUCTION.—Nothing in paragraph (1) shall be construed as affecting the application of section 514 of the Employee Retirement Income Security Act of 1974.

(b) COVERAGE OFFERED THROUGH EXCHANGE.—

(1) IN GENERAL.—In the case of health insurance coverage offered through the Health Insurance Exchange—

(A) the requirements of this title do not supercede any requirements (including requirements relating to genetic information nondiscrimination and mental health) applicable under title XXVII of the Public Health Service Act or under State law, except insofar as such requirements prevent the application of a requirement of this division, as determined by the Commissioner; and

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

(2) CONSTRUCTION.—In the case of coverage described in paragraph (1), nothing in such paragraph shall be construed as preventing the application of rights and remedies under State laws with respect to any requirement referred to in paragraph (1)(A).

SEC. 152. PROHIBITING DISCRIMINATION IN HEALTH CARE.

(a) IN GENERAL.—Except as otherwise explicitly permitted by this Act and by subsequent regulations consistent with this Act, all health care and related services (including insurance coverage and public health activities)

covered by this Act shall be provided without regard to personal characteristics extraneous to the provision of high quality health care or related services.

(b) IMPLEMENTATION.—To implement the requirement set forth in subsection (a), the Secretary of Health and Human Services shall, not later than 18 months after the date of the enactment of this Act, promulgate such regulations as are necessary or appropriate to insure that all health care and related services (including insurance coverage and public health activities) covered by this Act are provided (whether directly or through contractual, licensing, or other arrangements) without regard to personal characteristics extraneous to the provision of high quality health care or related services.

SEC. 153. WHISTLEBLOWER PROTECTION.

(a) RETALIATION PROHIBITED.—No employer may discharge any employee or otherwise discriminate against any employee with respect to his compensation, terms, conditions, or other privileges of employment because the employee (or any person acting pursuant to a request of the employee)—

(1) provided, caused to be provided, or is about to provide or cause to be provided to the employer, the Federal Government, or the attorney general of a State information relating to any violation of, or

any act or omission the employee reasonably believes to be a violation of any provision of this Act or any order, rule, or regulation promulgated under this Act;

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

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

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

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

(c) EMPLOYER DEFINED.—As used in this section, the term ''employer'' means any person (including one or more individuals, partnerships, associations, corporations, trusts, professional membership organization including a certification, disciplinary, or other professional body, unin-

corporated organizations, nongovernmental organizations, or trustees) engaged in profit or nonprofit business or industry whose activities are governed by this Act, and any agent, contractor, subcontractor, grantee, or consultant of such person.

(d) RULE OF CONSTRUCTION.—The rule of construction set forth in section 20109(h) of title 49, United States Code, shall also apply to this section.

SEC. 154. CONSTRUCTION REGARDING COLLECTIVE BARGAINING.

Nothing in this division shall be construed to alter of supercede any statutory or other obligation to engage in collective bargaining over the terms and conditions of employment related to health care.

SEC. 155. SEVERABILITY.

If any provision of this Act, or any application of such provision to any person or circumstance, is held to be unconstitutional, the remainder of the provisions of this Act and the application of the provision to any other person or circumstance shall not be affected.

Subtitle G—Early Investments

SEC. 161. ENSURING VALUE AND LOWER PREMIUMS.

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

"**SEC. 2714. ENSURING VALUE AND LOWER PREMIUMS.**

"(a) IN GENERAL.—Each health insurance issuer that offers health insurance coverage in the small or large group market shall provide that for any plan year in which the coverage has a medical loss ratio below a level specified by the Secretary, the issuer shall provide in a manner specified by the Secretary for rebates to enrollees of payment sufficient to meet such loss ratio. Such methodology shall be set at the highest level medical loss ratio possible that is designed to ensure adequate participation by issuers, competition in the health insurance market, and value for consumers so that their premiums are used for services.

"(b) UNIFORM DEFINITIONS.—The Secretary shall establish a uniform definition of medical loss ratio and methodology for determining how to calculate the medical loss ratio. Such methodology shall be designed to take into account the special circumstances of smaller plans, different types of plans, and newer plans.".

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

"**SEC. 2754. ENSURING VALUE AND LOWER PREMIUMS.**

"The provisions of section 2714 shall apply to health insurance coverage offered in the individual market in the

same manner as such provisions apply to health insurance coverage offered in the small or large group market.''.

(c) IMMEDIATE IMPLEMENTATION.—The amendments made by this section shall apply in the group and individual market for plan years beginning on or after January 1, 2011.

SEC. 162. ENDING HEALTH INSURANCE RESCISSION ABUSE.

(a) CLARIFICATION REGARDING APPLICATION OF GUARANTEED RENEWABILITY OF INDIVIDUAL HEALTH INSURANCE COVERAGE.—Section 2742 of the Public Health Service Act (42 U.S.C. 300gg–42) is amended—

(1) in its heading, by inserting ''**AND CONTINUATION IN FORCE, INCLUDING PROHIBITION OF RESCISSION,**'' after ''**GUARANTEED RENEWABILITY**''; and

(2) in subsection (a), by inserting '', including without rescission,'' after ''continue in force''.

(b) SECRETARIAL GUIDANCE REGARDING RESCISSIONS.—Section 2742 of such Act (42 U.S.C. 300gg–42) is amended by adding at the end the following:

''(f) RESCISSION.—A health insurance issuer may rescind health insurance coverage only upon clear and convincing evidence of fraud described in subsection (b)(2). The Secretary, no later than July 1, 2010, shall issue

guidance implementing this requirement, including procedures for independent, external third party review.''.

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

''**SEC. 2746. OPPORTUNITY FOR INDEPENDENT, EXTERNAL THIRD PARTY REVIEW IN CASES OF RESCISSION.**

''(a) NOTICE AND REVIEW RIGHT.—If a health insurance issuer determines to rescind health insurance coverage for an individual in the individual market, before such rescission may take effect the issuer shall provide the individual with notice of such proposed rescission and an opportunity for a review of such determination by an independent, external third party under procedures specified by the Secretary under section 2742(f).

''(b) INDEPENDENT DETERMINATION.—If the individual requests such review by an independent, external third party of a rescission of health insurance coverage, the coverage shall remain in effect until such third party determines that the coverage may be rescinded under the guidance issued by the Secretary under section 2742(f).''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply on and after October 1, 2010, with

respect to health insurance coverage issued before, on, or after such date.

SEC. 163. ADMINISTRATIVE SIMPLIFICATION.

(a) STANDARDIZING ELECTRONIC ADMINISTRATIVE TRANSACTIONS.—

(1) IN GENERAL.—Part C of title XI of the Social Security Act (42 U.S.C. 1320d et seq.) is amended by inserting after section 1173 the following new section:

"**SEC. 1173A. STANDARDIZE ELECTRONIC ADMINISTRATIVE TRANSACTIONS.**

''(a) STANDARDS FOR FINANCIAL AND ADMINISTRATIVE TRANSACTIONS.—

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

''(2) GOALS FOR FINANCIAL AND ADMINISTRATIVE TRANSACTIONS.—The goals for standards under paragraph (1) are that such standards shall—

''(A) be unique with no conflicting or redundant standards;

''(B) be authoritative, permitting no additions or constraints for electronic transactions, including companion guides;

''(C) be comprehensive, efficient and robust, requiring minimal augmentation by paper transactions or clarification by further communications;

''(D) enable the real-time (or near real-time) determination of an individual's financial responsibility at the point of service and, to the extent possible, prior to service, including whether the individual is eligible for a specific service with a specific physician at a specific facility, which may include utilization of a machine-readable health plan beneficiary identification card;

''(E) enable, where feasible, near real-time adjudication of claims;

''(F) provide for timely acknowledgment, response, and status reporting applicable to any electronic transaction deemed appropriate by the Secretary;

''(G) describe all data elements (such as reason and remark codes) in unambiguous terms, not permit optional fields, require that data elements be either required or conditioned upon set values in other fields, and prohibit additional conditions; and

''(H) harmonize all common data elements across administrative and clinical transaction standards.

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

''(4) REQUIREMENTS FOR SPECIFIC STANDARDS.—The standards under this section shall be developed, adopted and enforced so as to—

''(A) clarify, refine, complete, and expand, as needed, the standards required under section 1173;

''(B) require paper versions of standardized transactions to comply with the same standards as to data content such that a fully compliant, equivalent electronic transaction can be populated from the data from a paper version;

''(C) enable electronic funds transfers, in order to allow automated reconciliation with the related health care payment and remittance advice;

''(D) require timely and transparent claim and denial management processes, including tracking, adjudication, and appeal processing ;

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

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

''(5) BUILDING ON EXISTING STANDARDS.—In developing the standards under this section, the Secretary shall build upon existing and planned standards.

''(6) IMPLEMENTATION AND ENFORCEMENT.—Not later than 6 months after the date of the enactment of this section, the Secretary shall submit to the appropriate committees of Congress a plan for the implementation and enforcement, by not later than 5 years after such date of enactment, of the standards under this section. Such plan shall include—

"(A) a process and timeframe with milestones for developing the complete set of standards;

"(B) an expedited upgrade program for continually developing and approving additions and modifications to the standards as often as annually to improve their quality and extend their functionality to meet evolving requirements in health care;

"(C) programs to provide incentives for, and ease the burden of, implementation for certain health care providers, with special consideration given to such providers serving rural or underserved areas and ensure coordination with standards, implementation specifications, and certification criteria being adopted under the HITECH Act;

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

"(E) an estimate of total funds needed to ensure timely completion of the implementation plan; and

''(F) an enforcement process that includes timely investigation of complaints, random audits to ensure compliance, civil monetary and programmatic penalties for non-compliance consistent with existing laws and regulations, and a fair and reasonable appeals process building off of enforcement provisions under this part.

''(b) LIMITATIONS ON USE OF DATA.—Nothing in this section shall be construed to permit the use of information collected under this section in a manner that would adversely affect any individual.

''(c) PROTECTION OF DATA.—The Secretary shall ensure (through the promulgation of regulations or otherwise) that all data collected pursuant to subsection (a) are—

''(1) used and disclosed in a manner that meets the HIPAA privacy and security law (as defined in section 3009(a)(2) of the Public Health Service Act), including any privacy or security standard adopted under section 3004 of such Act; and

''(2) protected from all inappropriate internal use by any entity that collects, stores, or receives the data, including use of such data in determinations of eligibility (or continued eligibility) in health plans,

and from other inappropriate uses, as defined by the Secretary.''.

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

(A) in paragraph (7), by striking ''with reference to'' and all that follows and inserting ''with reference to a transaction or data element of health information in section 1173 means implementation specifications, certification criteria, operating rules, messaging formats, codes, and code sets adopted or established by the Secretary for the electronic exchange and use of information''; and

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

''(9) OPERATING RULES.—The term 'operating rules' means business rules for using and processing transactions. Operating rules should address the following:

''(A) Requirements for data content using available and established national standards.

''(B) Infrastructure requirements that establish best practices for streamlining data flow to yield timely execution of transactions.

''(C) Policies defining the transaction related rights and responsibilities for entities that are transmitting or receiving data.''.

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

(A) by inserting ''on behalf of an individual'' after ''1978)''; and

(B) by inserting ''on behalf of an individual'' after ''for a financial institution'' and

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

(1) STANDARD FOR HEALTH CLAIMS ATTACHMENTS.—Not later than 1 year after the date of the enactment of this Act, the Secretary of Health and Human Services shall promulgate a final rule to establish a standard for health claims attachment transaction described in section 1173(a)(2)(B) of the Social Security Act (42 U.S.C. 1320d-2(a)(2)(B)) and coordination of benefits.

(2) REVISION IN PROCESSING PAYMENT TRANSACTIONS BY FINANCIAL INSTITUTIONS.—

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

(i) by striking ''or is engaged'' and inserting ''and is engaged''; and

(ii) by inserting ''(other than as a business associate for a covered entity)'' after ''for a financial institution''.

(B) EFFECTIVE DATE.—The amendments made by paragraph (1) shall apply to transactions occurring on or after such date (not later than 6 months after the date of the enactment of this Act) as the Secretary of Health and Human Services shall specify.

SEC. 164. REINSURANCE PROGRAM FOR RETIREES.

(a) ESTABLISHMENT.—

(1) IN GENERAL.—Not later than 90 days after the date of the enactment of this Act, the Secretary of Health and Human Services shall establish a temporary reinsurance program (in this section referred to as the ''reinsurance program'') to provide reimbursement to assist participating employment-based plans with the cost of providing health benefits to retirees and to eligible spouses, surviving spouses and dependents of such retirees.

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

(A) The term ''eligible employment-based plan'' means a group health benefits plan that—

(i) is maintained by one or more employers, former employers or employee associations, or a voluntary employees' beneficiary association, or a committee or board of individuals appointed to administer such plan, and

(ii) provides health benefits to retirees.

(B) The term ''health benefits'' means medical, surgical, hospital, prescription drug, and such other benefits as shall be determined by the Secretary, whether self-funded or delivered through the purchase of insurance or otherwise.

(C) The term ''participating employment-based plan'' means an eligible employment-based plan that is participating in the reinsurance program.

(D) The term ''retiree'' means, with respect to a participating employment-benefit plan, an individual who—

(i) is 55 years of age or older;

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

(iii) is not an active employee of an employer maintaining the plan or of any employer that makes or has made substantial contributions to fund such plan.

(E) The term ''Secretary'' means Secretary of Health and Human Services.

(b) PARTICIPATION.—To be eligible to participate in the reinsurance program, an eligible employment-based plan shall submit to the Secretary an application for participation in the program, at such time, in such manner, and containing such information as the Secretary shall require.

(c) PAYMENT.—

(1) SUBMISSION OF CLAIMS.—

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

(B) BASIS FOR CLAIMS.—Each claim submitted under subparagraph (A) shall be based on the actual amount expended by the partici-

pating employment-based plan involved within the plan year for the appropriate employment based health benefits provided to a retiree or to the spouse, surviving spouse, or dependent of a retiree. In determining the amount of any claim for purposes of this subsection, the participating employment-based plan shall take into account any negotiated price concessions (such as discounts, direct or indirect subsidies, rebates, and direct or indirect remunerations) obtained by such plan with respect to such health benefits. For purposes of calculating the amount of any claim, the costs paid by the retiree or by the spouse, surviving spouse, or dependent of the retiree in the form of deductibles, co-payments, and co-insurance shall be included along with the amounts paid by the participating employment-based plan.

(2) PROGRAM PAYMENTS AND LIMIT.—If the Secretary determines that a participating employment-based plan has submitted a valid claim under paragraph (1), the Secretary shall reimburse such plan for 80 percent of that portion of the costs attributable to such claim that exceeds $15,000, but is less than $90,000. Such amounts shall be adjusted

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

(3) USE OF PAYMENTS.—Amounts paid to a participating employment-based plan under this subsection shall be used to lower the costs borne directly by the participants and beneficiaries for health benefits provided under such plan in the form of premiums, co-payments, deductibles, co-insurance, or other out-of-pocket costs. Such payments shall not be used to reduce the costs of an employer maintaining the participating employment-based plan. The Secretary shall develop a mechanism to monitor the appropriate use of such payments by such plans.

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

(A) an appeals process to permit participating employment-based plans to appeal a determination of the Secretary with respect to claims submitted under this section; and

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

(5) AUDITS.—The Secretary shall conduct annual audits of claims data submitted by partici-

pating employment-based plans under this section to ensure that they are in compliance with the requirements of this section.

(d) RETIREE RESERVE TRUST FUND.—

(1) ESTABLISHMENT.—

(A) IN GENERAL.—There is established in the Treasury of the United States a trust fund to be known as the ''Retiree Reserve Trust Fund'' (referred to in this section as the ''Trust Fund''), that shall consist of such amounts as may be appropriated or credited to the Trust Fund as provided for in this subsection to enable the Secretary to carry out the reinsurance program. Such amounts shall remain available until expended.

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

(C) APPROPRIATIONS FROM THE TRUST FUND.—

(i) IN GENERAL.—Amounts in the Trust Fund are appropriated to provide funding to carry out the reinsurance program and shall be used to carry out such program.

(ii) BUDGETARY IMPLICATIONS.—Amounts appropriated under clause (i), and outlays flowing from such appropriations, shall not be taken into account for purposes of any budget enforcement procedures including allocations under section 302(a) and (b) of the Balanced Budget and Emergency Deficit Control Act and budget resolutions for fiscal years during which appropriations are made from the Trust Fund.

(iii) LIMITATION TO AVAILABLE FUNDS.—The Secretary has the authority to stop taking applications for participation in the program or take such other steps in reducing expenditures under the reinsurance program in order to ensure that expenditures under the reinsurance program do not exceed the funds available under this subsection.

TITLE II—HEALTH INSURANCE EXCHANGE AND RELATED PROVISIONS

Subtitle A—Health Insurance Exchange

SEC. 201. ESTABLISHMENT OF HEALTH INSURANCE EXCHANGE; OUTLINE OF DUTIES; DEFINITIONS.

(a) ESTABLISHMENT.—There is established within the Health Choices Administration and under the direction of the Commissioner a Health Insurance Exchange in order to facilitate access of individuals and employers, through a transparent process, to a variety of choices of affordable, quality health insurance coverage, including a public health insurance option.

(b) OUTLINE OF DUTIES OF COMMISSIONER.—In accordance with this subtitle and in coordination with appropriate Federal and State officials as provided under section 143(b), the Commissioner shall—

(1) under section 204 establish standards for, accept bids from, and negotiate and enter into contracts with, QHBP offering entities for the offering of health benefits plans through the Health Insurance Exchange, with different levels of benefits required under section 203, and including with respect to oversight and enforcement;

(2) under section 205 facilitate outreach and enrollment in such plans of Exchange-eligible individuals and employers described in section 202; and

(3) conduct such activities related to the Health Insurance Exchange as required, including establishment of a risk pooling mechanism under section 206 and consumer protections under subtitle D of title I.

(c) EXCHANGE-PARTICIPATING HEALTH BENEFITS PLAN DEFINED.—In this division, the term ''Exchange-participating health benefits plan'' means a qualified health benefits plan that is offered through the Health Insurance Exchange.

SEC. 202. EXCHANGE-ELIGIBLE INDIVIDUALS AND EMPLOYERS.

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

(b) DEFINITIONS.—In this division:

(1) EXCHANGE-ELIGIBLE INDIVIDUAL.—The term ''Exchange-eligible individual'' means an individual who is eligible under this section to be enrolled through the Health Insurance Exchange in an

Exchange-participating health benefits plan and, with respect to family coverage, includes dependents of such individual.

(2) EXCHANGE-ELIGIBLE EMPLOYER.—The term ''Exchange-eligible employer'' means an employer that is eligible under this section to enroll through the Health Insurance Exchange employees of the employer (and their dependents) in Exchange-eligible health benefits plans.

(3) EMPLOYMENT-RELATED DEFINITIONS.—The terms ''employer'', ''employee'', ''full-time employee'', and ''part-time employee'' have the meanings given such terms by the Commissioner for purposes of this division.

(c) TRANSITION.—Individuals and employers shall only be eligible to enroll or participate in the Health Insurance Exchange in accordance with the following transition schedule:

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

(A) individuals described in subsection (d)(1), including individuals described in paragraphs (3) and (4) of subsection (d); and

(B) smallest employers described in subsection (e)(1).

(2) SECOND YEAR.—In Y2—

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

(B) smaller employers described in subsection (e)(2).

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

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

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

(d) INDIVIDUALS.—

(1) INDIVIDUAL DESCRIBED.—Subject to the succeeding provisions of this subsection, an individual described in this paragraph is an individual who—

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

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

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

(2) ACCEPTABLE COVERAGE.—For purposes of this division, the term ''acceptable coverage'' means any of the following:

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

(B) GRANDFATHERED HEALTH INSURANCE COVERAGE; COVERAGE UNDER CURRENT GROUP HEALTH PLAN.—Coverage under a grandfathered health insurance coverage (as defined in subsection (a) of section 102) or under a current group health plan (described in subsection (b) of such section).

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

(D) MEDICAID.—Coverage for medical assistance under title XIX of the Social Security Act, excluding such coverage that is only available because of the application of subsection (u), (z), or (aa) of section 1902 of such Act

(E) MEMBERS OF THE ARMED FORCES AND DEPENDENTS (INCLUDING TRICARE).—Coverage under chapter 55 of title 10, United States Code, including similar coverage furnished under section 1781 of title 38 of such Code.

(F) VA.—Coverage under the veteran's health care program under chapter 17 of title 38, United States Code, but only if the coverage for the individual involved is determined by the Commissioner in coordination with the Secretary of Treasury to be not less than a level specified by the Commissioner and Secretary of Veteran's Affairs, in coordination with the Secretary of Treasury, based on the individual's priority for services as provided under section 1705(a) of such title.

(G) OTHER COVERAGE.—Such other health benefits coverage, such as a State health benefits risk pool, as the Commissioner, in coordination with the Secretary of the Treasury, recognizes for purposes of this paragraph.

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

(3) TREATMENT OF CERTAIN NON-TRADITIONAL MEDICAID ELIGIBLE INDIVIDUALS.—An individual who is a non-traditional Medicaid eligible individual (as defined in section 205(e)(4)(C)) in a State may be an Exchange-eligible individual if the individual was enrolled in a qualified health benefits plan, grandfathered health insurance coverage, or current group health plan during the 6 months before the individual became a non-traditional Medicaid eligible individual. During the period in which such an individual has chosen to enroll in an Exchange-participating health benefits plan, the individual is not also eligible for medical assistance under Medicaid.

(4) CONTINUING ELIGIBILITY PERMITTED.—

(A) IN GENERAL.—Except as provided in subparagraph (B), once an individual qualifies as an Exchange-eligible individual under this subsection (including as an employee or dependent of an employee of an Exchange-eligible employer) and enrolls under an Exchange-participating health benefits plan through the Health Insurance Exchange, the individual shall continue to be treated as an Exchange-eligible individual until the individual is no longer enrolled

with an Exchange-participating health benefits plan.

(B) EXCEPTIONS.—

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

(I) under part A of the Medicare program;

(II) under the Medicaid program as a Medicaid eligible individual, except as permitted under paragraph (3) or clause (ii); or

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

(ii) TRANSITION PERIOD.—In the case described in clause (i)(II), the Commissioner shall permit the individual to continue treatment under subparagraph (A) until such limited time as the Commissioner determines it is administratively feasible, consistent with minimizing disruption in the individual's access to health care.

(e) EMPLOYERS.—

(1) SMALLEST EMPLOYER.—Subject to paragraph (4), smallest employers described in this paragraph are employers with 10 or fewer employees.

(2) SMALLER EMPLOYERS.—Subject to paragraph (4), smaller employers described in this paragraph are employers that are not smallest employers described in paragraph (1) and have 20 or fewer employees.

(3) LARGER EMPLOYERS.—

(A) IN GENERAL.—Beginning with Y3, the Commissioner may permit employers not described in paragraph (1) or (2) to be Exchange-eligible employers.

(B) PHASE-IN.—In applying subparagraph (A), the Commissioner may phase-in the application of such subparagraph based on the number of full-time employees of an employer and such other considerations as the Commissioner deems appropriate.

(4) CONTINUING ELIGIBILITY.—Once an employer is permitted to be an Exchange-eligible employer under this subsection and enrolls employees through the Health Insurance Exchange, the employer shall continue to be treated as an Exchange-eligible employer for each subsequent plan year re-

gardless of the number of employees involved unless and until the employer meets the requirement of section 311(a) through paragraph (1) of such section by offering a group health plan and not through offering Exchange-participating health benefits plan.

(5) EMPLOYER PARTICIPATION AND CONTRIBUTIONS.—

(A) SATISFACTION OF EMPLOYER RESPONSIBILITY.—For any year in which an employer is an Exchange-eligible employer, such employer may meet the requirements of section 312 with respect to employees of such employer by offering such employees the option of enrolling with Exchange-participating health benefits plans through the Health Insurance Exchange consistent with the provisions of subtitle B of title III.

(B) EMPLOYEE CHOICE.—Any employee offered Exchange-participating health benefits plans by the employer of such employee under subparagraph (A) may choose coverage under any such plan. That choice includes, with respect to family coverage, coverage of the dependents of such employee.

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

(7) OTHER COUNTING RULES.—The Commissioner shall establish rules relating to how employees are counted for purposes of carrying out this subsection.

(f) SPECIAL SITUATION AUTHORITY.—The Commissioner shall have the authority to establish such rules as may be necessary to deal with special situations with regard to uninsured individuals and employers participating as Exchange-eligible individuals and employers, such as transition periods for individuals and employers who gain, or lose, Exchange-eligible participation status, and to establish grace periods for premium payment.

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

(h) EXCHANGE ACCESS STUDY.—

(1) IN GENERAL.—The Commissioner shall conduct a study of access to the Health Insurance Exchange for individuals and for employers, including individuals and employers who are not eligible and enrolled in Exchange-participating health benefits plans. The goal of the study is to determine if there are significant groups and types of individuals and employers who are not Exchange eligible individuals or employers, but who would have improved benefits and affordability if made eligible for coverage in the Exchange.

(2) ITEMS INCLUDED IN STUDY.—Such study also shall examine—

(A) the terms, conditions, and affordability of group health coverage offered by employers and QHBP offering entities outside of the Exchange compared to Exchange-participating health benefits plans; and

(B) the affordability-test standard for access of certain employed individuals to coverage in the Health Insurance Exchange.

(3) REPORT.—Not later than January 1 of Y3, in Y6, and thereafter, the Commissioner shall submit to Congress on the study conducted under this subsection and shall include in such report rec-

ommendations regarding changes in standards for Exchange eligibility for for individuals and employers.

SEC. 203. BENEFITS PACKAGE LEVELS.

(a) IN GENERAL.—The Commissioner shall specify the benefits to be made available under Exchange-participating health benefits plans during each plan year, consistent with subtitle C of title I and this section.

(b) LIMITATION ON HEALTH BENEFITS PLANS OFFERED BY OFFERING ENTITIES.—The Commissioner may not enter into a contract with a QHBP offering entity under section 204(c) for the offering of an Exchange-participating health benefits plan in a service area unless the following requirements are met:

(1) REQUIRED OFFERING OF BASIC PLAN.—The entity offers only one basic plan for such service area.

(2) OPTIONAL OFFERING OF ENHANCED PLAN.—If and only if the entity offers a basic plan for such service area, the entity may offer one enhanced plan for such area.

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

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

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

(c) SPECIFICATION OF BENEFIT LEVELS FOR PLANS.—

(1) IN GENERAL.—The Commissioner shall establish the following standards consistent with this subsection and title I:

(A) BASIC, ENHANCED, AND PREMIUM PLANS.—Standards for 3 levels of Exchange-participating health benefits plans: basic, enhanced, and premium (in this division referred to as a ''basic plan'', ''enhanced plan'', and ''premium plan'', respectively).

(B) PREMIUM-PLUS PLAN BENEFITS.—Standards for additional benefits that may be offered, consistent with this subsection and subtitle C of title I, under a premium plan (such a plan with additional benefits referred to in this division as a ''premium-plus plan'') .

(2) BASIC PLAN.—

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

(B) TIERED COST-SHARING FOR AFFORDABLE CREDIT ELIGIBLE INDIVIDUALS.—In the case of an affordable credit eligible individual (as defined in section 242(a)(1)) enrolled in an Exchange-participating health benefits plan, the benefits under a basic plan are modified to provide for the reduced cost-sharing for the income tier applicable to the individual under section 244(c).

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

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

(5) PREMIUM-PLUS PLAN.—A premium-plus plan is a premium plan that also provides additional benefits, such as adult oral health and vision care, approved by the Commissioner. The portion of the

premium that is attributable to such additional benefits shall be separately specified.

(6) RANGE OF PERMISSIBLE VARIATION IN COST-SHARING.—The Commissioner shall establish a permissible range of variation of cost-sharing for each basic, enhanced, and premium plan, except with respect to any benefit for which there is no cost-sharing permitted under the essential benefits package. Such variation shall permit a variation of not more than plus (or minus) 10 percent in cost-sharing with respect to each benefit category specified under section 122.

(d) TREATMENT OF STATE BENEFIT MANDATES.—Insofar as a State requires a health insurance issuer offering health insurance coverage to include benefits beyond the essential benefits package, such requirement shall continue to apply to an Exchange-participating health benefits plan, if the State has entered into an arrangement satisfactory to the Commissioner to reimburse the Commissioner for the amount of any net increase in affordability premium credits under subtitle C as a result of an increase in premium in basic plans as a result of application of such requirement.

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

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

(1) OFFERING ENTITY AND PLAN STANDARDS.—The Commissioner shall—

(A) establish standards necessary to implement the requirements of this title and title I for—

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

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

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

(2) SOLICITING AND NEGOTIATING BIDS; CONTRACTS.—The Commissioner shall—

(A) solicit bids from QHBP offering entities for the offering of Exchange-participating health benefits plans;

(B) based upon a review of such bids, negotiate with such entities for the offering of such plans; and

(C) enter into contracts with such entities for the offering of such plans through the Health Insurance Exchange under terms (consistent with this title) negotiated between the Commissioner and such entities.

(3) FAR NOT APPLICABLE.—The provisions of the Federal Acquisition Regulation shall not apply to contracts between the Commissioner and QHBP offering entities for the offering of Exchange-participating health benefits plans under this title.

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

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

(2) DATA REPORTING.—The entity shall provide for the reporting of such information as the Commissioner may specify, including information necessary to administer the risk pooling mechanism described in section 206(b) and information to address disparities in health and health care.

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

(4) ENROLLMENT.—The entity shall accept all enrollments under this subtitle, subject to such exceptions (such as capacity limitations) in accordance with the requirements under title I for a qualified health benefits plan. The entity shall notify the Commissioner if the entity projects or anticipates reaching such a capacity limitation that would result in a limitation in enrollment.

(5) RISK POOLING PARTICIPATION.—The entity shall participate in such risk pooling mechanism as the Commissioner establishes under section 206(b).

(6) ESSENTIAL COMMUNITY PROVIDERS.—With respect to the basic plan offered by the entity, the entity shall contract for outpatient services with covered entities (as defined in section 340B(a)(4) of the Public Health Service Act, as in effect as of July 1, 2009). The Commissioner shall specify the extent to which and manner in which the previous sentence shall apply in the case of a basic plan with respect to which the Commissioner determines provides sub-

stantially all benefits through a health maintenance organization, as defined in section 2791(b)(3) of the Public Health Service Act.

(7) CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES AND COMMUNICATIONS.—The entity shall provide for culturally and linguistically appropriate communication and health services.

(8) ADDITIONAL REQUIREMENTS.—The entity shall comply with other applicable requirements of this title, as specified by the Commissioner, which shall include standards regarding billing and collection practices for premiums and related grace periods and which may include standards to ensure that the entity does not use coercive practices to force providers not to contract with other entities offering coverage through the Health Insurance Exchange.

(c) CONTRACTS.—

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

(2) TERM.—Each contract with a QHBP offering entity under this section shall be for a term of not less than one year, but may be made automati-

cally renewable from term to term in the absence of notice of termination by either party.

(3) ENFORCEMENT OF NETWORK ADEQUACY.—In the case of a health benefits plan of a QHBP offering entity that uses a provider network, the contract under this section with the entity shall provide that if—

(A) the Commissioner determines that such provider network does not meet such standards as the Commissioner shall establish under section 115; and

(B) an individual enrolled in such plan receives an item or service from a provider that is not within such network;

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

(4) OVERSIGHT AND ENFORCEMENT RESPONSIBILITIES.—The Commissioner shall establish processes, in coordination with State insurance regulators, to oversee, monitor, and enforce applicable requirements of this title with respect to QHBP offering entities offering Exchange-participating health benefits plans and such plans, including the mar-

keting of such plans. Such processes shall include the following:

(A) GRIEVANCE AND COMPLAINT MECHANISMS.—The Commissioner shall establish, in coordination with State insurance regulators, a process under which Exchange-eligible individuals and employers may file complaints concerning violations of such standards.

(B) ENFORCEMENT.—In carrying out authorities under this division relating to the Health Insurance Exchange, the Commissioner may impose one or more of the intermediate sanctions described in section 142(c).

(C) TERMINATION.—

(i) IN GENERAL.—The Commissioner may terminate a contract with a QHBP offering entity under this section for the offering of an Exchange-participating health benefits plan if such entity fails to comply with the applicable requirements of this title. Any determination by the Commissioner to terminate a contract shall be made in accordance with formal investigation and compliance procedures established by the Commissioner under which—

(I) the Commissioner provides the entity with the reasonable opportunity to develop and implement a corrective action plan to correct the deficiencies that were the basis of the Commissioner's determination; and

(II) the Commissioner provides the entity with reasonable notice and opportunity for hearing (including the right to appeal an initial decision) before terminating the contract.

(ii) EXCEPTION FOR IMMINENT AND SERIOUS RISK TO HEALTH.—Clause (i) shall not apply if the Commissioner determines that a delay in termination, resulting from compliance with the procedures specified in such clause prior to termination, would pose an imminent and serious risk to the health of individuals enrolled under the qualified health benefits plan of the QHBP offering entity.

(D) CONSTRUCTION.—Nothing in this subsection shall be construed as preventing the application of other sanctions under subtitle E of

title I with respect to an entity for a violation of such a requirement.

SEC. 205. OUTREACH AND ENROLLMENT OF EXCHANGE-ELIGIBLE INDIVIDUALS AND EMPLOYERS IN EXCHANGE-PARTICIPATING HEALTH BENEFITS PLAN.

(a) IN GENERAL.—

(1) OUTREACH.—The Commissioner shall conduct outreach activities consistent with subsection (c), including through use of appropriate entities as described in paragraph (4) of such subsection, to inform and educate individuals and employers about the Health Insurance Exchange and Exchange-participating health benefits plan options. Such outreach shall include outreach specific to vulnerable populations, such as children, individuals with disabilities, individuals with mental illness, and individuals with other cognitive impairments.

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

(3) ENROLLMENT.—The Commissioner shall establish and carry out an enrollment process for Exchange-eligible individuals and employers, including

at community locations, in accordance with subsection (b).

(b) ENROLLMENT PROCESS.—

(1) IN GENERAL.—The Commissioner shall establish a process consistent with this title for enrollments in Exchange-participating health benefits plans. Such process shall provide for enrollment through means such as the mail, by telephone, electronically, and in person.

(2) ENROLLMENT PERIODS.—

(A) OPEN ENROLLMENT PERIOD.—The Commissioner shall establish an annual open enrollment period during which an Exchange-eligible individual or employer may elect to enroll in an Exchange-participating health benefits plan for the following plan year and an enrollment period for affordability credits under subtitle C. Such periods shall be during September through November of each year, or such other time that would maximize timeliness of income verification for purposes of such subtitle. The open enrollment period shall not be less than 30 days.

(B) SPECIAL ENROLLMENT.—The Commissioner shall also provide for special enroll-

ment periods to take into account special circumstances of individuals and employers, such as an individual who—

(i) loses acceptable coverage;

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

(iii) moves outside the service area of the Exchange-participating health benefits plan in which the individual is enrolled; or

(iv) experiences a significant change in income.

(C) ENROLLMENT INFORMATION.—The Commissioner shall provide for the broad dissemination of information to prospective enrollees on the enrollment process, including before each open enrollment period. In carrying out the previous sentence, the Commissioner may work with other appropriate entities to facilitate such provision of information.

(3) AUTOMATIC ENROLLMENT FOR NON-MEDICAID ELIGIBLE INDIVIDUALS.—

(A) IN GENERAL.—The Commissioner shall provide for a process under which individuals who are Exchange-eligible individuals described in subparagraph (B) are automatically

enrolled under an appropriate Exchange-participating health benefits plan. Such process may involve a random assignment or some other form of assignment that takes into account the health care providers used by the individual involved or such other relevant factors as the Commissioner may specify.

(B) SUBSIDIZED INDIVIDUALS DESCRIBED.—An individual described in this subparagraph is an Exchange-eligible individual who is either of the following:

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

(I) has applied for, and been determined eligible for, affordability credits under subtitle C;

(II) has not opted out from receiving such affordability credit; and

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

(ii) INDIVIDUALS ENROLLED IN A TERMINATED PLAN.—The individual is enrolled in an Exchange-participating health benefits plan that is terminated (during or

at the end of a plan year) and who does not otherwise enroll in another Exchange-participating health benefits plan.

(4) DIRECT PAYMENT OF PREMIUMS TO PLANS.—Under the enrollment process, individuals enrolled in an Exchange-partcipating health benefits plan shall pay such plans directly, and not through the Commissioner or the Health Insurance Exchange.

(c) COVERAGE INFORMATION AND ASSISTANCE.—

(1) COVERAGE INFORMATION.—The Commissioner shall provide for the broad dissemination of information on Exchange-participating health benefits plans offered under this title. Such information shall be provided in a comparative manner, and shall include information on benefits, premiums, cost-sharing, quality, provider networks, and consumer satisfaction.

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

(A) provide for the operation of a toll-free telephone hotline to respond to requests for assistance and maintain an Internet website through which individuals may obtain informa-

tion on coverage under Exchange-participating health benefits plans and file complaints;

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

(C) assist Exchange-eligible individuals in selecting Exchange-participating health benefits plans and obtaining benefits through such plans; and

(D) ensure that the Internet website described in subparagraph (A) and the information described in subparagraph (B) is developed using plain language (as defined in section 133(a)(2)).

(3) USE OF OTHER ENTITIES.—In carrying out this subsection, the Commissioner may work with other appropriate entities to facilitate the dissemination of information under this subsection and to provide assistance as described in paragraph (2).

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

(1) COVERAGE FOR CERTAIN NEWBORNS.—

(A) IN GENERAL.—In the case of a child born in the United States who at the time of birth is not otherwise covered under acceptable

coverage, for the period of time beginning on the date of birth and ending on the date the child otherwise is covered under acceptable coverage (or, if earlier, the end of the month in which the 60-day period, beginning on the date of birth, ends), the child shall be deemed—

(i) to be a non-traditional Medicaid eligible individual (as defined in subsection (e)(5)) for purposes of this division and Medicaid; and

(ii) to have elected to enroll in Medicaid through the application of paragraph (3).

(B) EXTENDED TREATMENT AS TRADITIONAL MEDICAID ELIGIBLE INDIVIDUAL.—In the case of a child described in subparagraph (A) who at the end of the period referred to in such subparagraph is not otherwise covered under acceptable coverage, the child shall be deemed (until such time as the child obtains such coverage or the State otherwise makes a determination of the child's eligibility for medical assistance under its Medicaid plan pursuant to section 1943(c)(1) of the Social Security Act) to be a traditional Medicaid eligible indi-

vidual described in section 1902(l)(1)(B) of such Act.

(2) CHIP TRANSITION.—A child who, as of the day before the first day of Y1, is eligible for child health assistance under title XXI of the Social Security Act (including a child receiving coverage under an arrangement described in section 2101(a)(2) of such Act) is deemed as of such first day to be an Exchange-eligible individual unless the individual is a traditional Medicaid eligible individual as of such day.

(3) AUTOMATIC ENROLLMENT OF MEDICAID ELIGIBLE INDIVIDUALS INTO MEDICAID.—The Commissioner shall provide for a process under which an individual who is described in section 202(d)(3) and has not elected to enroll in an Exchange-participating health benefits plan is automatically enrolled under Medicaid.

(4) NOTIFICATIONS.—The Commissioner shall notify each State in Y1 and for purposes of section 1902(gg)(1) of the Social Security Act (as added by section 1703(a)) whether the Health Insurance Exchange can support enrollment of children described in paragraph (2) in such State in such year.

(e) MEDICAID COVERAGE FOR MEDICAID ELIGIBLE INDIVIDUALS.—

(1) IN GENERAL.—

(A) CHOICE FOR LIMITED EXCHANGE-ELIGIBLE INDIVIDUALS.—As part of the enrollment process under subsection (b), the Commissioner shall provide the option, in the case of an Exchange-eligible individual described in section 202(d)(3), for the individual to elect to enroll under Medicaid instead of under an Exchange-participating health benefits plan. Such an individual may change such election during an enrollment period under subsection (b)(2).

(B) MEDICAID ENROLLMENT OBLIGATION.—An Exchange eligible individual may apply, in the manner described in section 241(b)(1), for a determination of whether the individual is a Medicaid-eligible individual. If the individual is determined to be so eligible, the Commissioner, through the Medicaid memorandum of understanding, shall provide for the enrollment of the individual under the State Medicaid plan in accordance with the Medicaid memorandum of understanding under paragraph (4). In the case of such an enrollment,

the State shall provide for the same periodic redetermination of eligibility under Medicaid as would otherwise apply if the individual had directly applied for medical assistance to the State Medicaid agency.

(2) NON-TRADITIONAL MEDICAID ELIGIBLE INDIVIDUALS.—In the case of a non-traditional Medicaid eligible individual described in section 202(d)(3) who elects to enroll under Medicaid under paragraph (1)(A), the Commissioner shall provide for the enrollment of the individual under the State Medicaid plan in accordance with the Medicaid memorandum of understanding under paragraph (4).

(3) COORDINATED ENROLLMENT WITH STATE THROUGH MEMORANDUM OF UNDERSTANDING.—The Commissioner, in consultation with the Secretary of Health and Human Services, shall enter into a memorandum of understanding with each State (each in this division referred to as a ''Medicaid memorandum of understanding'') with respect to coordinating enrollment of individuals in Exchange-participating health benefits plans and under the State's Medicaid program consistent with this section and to otherwise coordinate the implementa-

tion of the provisions of this division with respect to the Medicaid program. Such memorandum shall permit the exchange of information consistent with the limitations described in section 1902(a)(7) of the Social Security Act. Nothing in this section shall be construed as permitting such memorandum to modify or vitiate any requirement of a State Medicaid plan.

(4) MEDICAID ELIGIBLE INDIVIDUALS.—For purposes of this division:

(A) MEDICAID ELIGIBLE INDIVIDUAL.—The term ''Medicaid eligible individual'' means an individual who is eligible for medical assistance under Medicaid.

(B) TRADITIONAL MEDICAID ELIGIBLE INDIVIDUAL.—The term ''traditional Medicaid eligible individual'' means a Medicaid eligible individual other than an individual who is—

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

(ii) a childless adult not described in section 1902(a)(10)(A) or (C) of such Act

(as in effect as of the day before the date of the enactment of this Act).

(C) NON-TRADITIONAL MEDICAID ELIGIBLE INDIVIDUAL.—The term ''non-traditional Medicaid eligible individual'' means a Medicaid eligible individual who is not a traditional Medicaid eligible individual.

(f) EFFECTIVE CULTURALLY AND LINGUISTICALLY APPROPRIATE COMMUNICATION.—In carrying out this section, the Commissioner shall establish effective methods for communicating in plain language and a culturally and linguistically appropriate manner.

SEC. 206. OTHER FUNCTIONS.

(a) COORDINATION OF AFFORDABILITY CREDITS.—The Commissioner shall coordinate the distribution of affordability premium and cost-sharing credits under subtitle C to QHBP offering entities offering Exchange-participating health benefits plans.

(b) COORDINATION OF RISK POOLING.—The Commissioner shall establish a mechanism whereby there is an adjustment made of the premium amounts payable among QHBP offering entities offering Exchange-participating health benefits plans of premiums collected for such plans that takes into account (in a manner specified by the Commissioner) the differences in the risk characteristics of in-

dividuals and employers enrolled under the different Exchange-participating health benefits plans offered by such entities so as to minimize the impact of adverse selection of enrollees among the plans offered by such entities.

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

(1) ESTABLISHMENT; APPOINTMENT.—There is hereby established the Office of the Special Inspector General for the Health Insurance Exchange, to be headed by a Special Inspector General for the Health Insurance Exchange (in this subsection referred to as the ''Special Inspector General'') to be appointed by the President, by and with the advice and consent of the Senate. The nomination of an individual as Special Inspector General shall be made as soon as practicable after the establishment of the program under this subtitle.

(2) DUTIES.—The Special Inspector General shall—

(A) conduct, supervise, and coordinate audits, evaluations and investigations of the Health Insurance Exchange to protect the integrity of the Health Insurance Exchange, as well as the health and welfare of participants in the Exchange;

(B) report both to the Commissioner and to the Congress regarding program and management problems and recommendations to correct them;

(C) have other duties (described in paragraphs (2) and (3) of section 121 of division A of Public Law 110–343) in relation to the duties described in the previous subparagraphs; and

(D) have the authorities provided in section 6 of the Inspector General Act of 1978 in carrying out duties under this paragraph.

(3) APPLICATION OF OTHER SPECIAL INSPECTOR GENERAL PROVISIONS.—The provisions of subsections (b) (other than paragraphs (1) and (3)), (d) (other than paragraph (1)), and (e) of section 121 of division A of the Emergency Economic Stabilization Act of 2009 (Public Law 110–343) shall apply to the Special Inspector General under this subsection in the same manner as such provisions apply to the Special Inspector General under such section.

(4) REPORTS.—Not later than one year after the confirmation of the Special Inspector General, and annually thereafter, the Special Inspector General shall submit to the appropriate committees of

Congress a report summarizing the activities of the Special Inspector General during the one year period ending on the date such report is submitted.

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

SEC. 207. HEALTH INSURANCE EXCHANGE TRUST FUND.

(a) ESTABLISHMENT OF HEALTH INSURANCE EXCHANGE TRUST FUND.—There is created within the Treasury of the United States a trust fund to be known as the ''Health Insurance Exchange Trust Fund'' (in this section referred to as the ''Trust Fund''), consisting of such amounts as may be appropriated or credited to the Trust Fund under this section or any other provision of law.

(b) PAYMENTS FROM TRUST FUND.—The Commissioner shall pay from time to time from the Trust Fund such amounts as the Commissioner determines are necessary to make payments to operate the Health Insurance Exchange, including payments under subtitle C (relating to affordability credits).

(c) TRANSFERS TO TRUST FUND.—

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

(A) TAXES ON INDIVIDUALS NOT OBTAINING ACCEPTABLE COVERAGE.—The amounts received in the Treasury under section 59B of the Internal Revenue Code of 1986 (relating to requirement of health insurance coverage for individuals).

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

(C) EXCISE TAX ON FAILURES TO MEET CERTAIN HEALTH COVERAGE REQUIREMENTS.—The amounts received in the Treasury under section 4980H(b) (relating to excise tax with respect to failure to meet health coverage participation requirements).

(2) APPROPRIATIONS TO COVER GOVERNMENT CONTRIBUTIONS.—There are hereby appropriated, out of any moneys in the Treasury not otherwise appropriated, to the Trust Fund, an amount equivalent to the amount of payments made from the Trust Fund under subsection (b) plus such amounts as are

necessary reduced by the amounts deposited under paragraph (1).

(d) APPLICATION OF CERTAIN RULES.—Rules similar to the rules of subchapter B of chapter 98 of the Internal Revenue Code of 1986 shall apply with respect to the Trust Fund.

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

(a) IN GENERAL.—If—

(1) a State (or group of States, subject to the approval of the Commissioner) applies to the Commissioner for approval of a State-based Health Insurance Exchange to operate in the State (or group of States); and

(2) the Commissioner approves such State-based Health Insurance Exchange,

then, subject to subsections (c) and (d), the State-based Health Insurance Exchange shall operate, instead of the Health Insurance Exchange, with respect to such State (or group of States). The Commissioner shall approve a State-based Health Insurance Exchange if it meets the requirements for approval under subsection (b).

(b) REQUIREMENTS FOR APPROVAL.—The Commissioner may not approve a State-based Health Insurance

Exchange under this section unless the following requirements are met:

(1) The State-based Health Insurance Exchange must demonstrate the capacity to and provide assurances satisfactory to the Commissioner that the State-based Health Insurance Exchange will carry out the functions specified for the Health Insurance Exchange in the State (or States) involved, including—

(A) negotiating and contracting with QHBP offering entities for the offering of Exchange-participating health benefits plan, which satisfy the standards and requirements of this title and title I;

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

(C) the establishment of sufficient local offices to meet the needs of Exchange-eligible individuals and employers;

(D) administering affordability credits under subtitle B using the same methodologies (and at least the same income verification methods) as would otherwise apply under such subtitle and at a cost to the Federal Govern-

ment which does exceed the cost to the Federal Government if this section did not apply; and

(E) enforcement activities consistent with federal requirements.

(2) There is no more than one Health Insurance Exchange operating with respect to any one State.

(3) The State provides assurances satisfactory to the Commissioner that approval of such an Exchange will not result in any net increase in expenditures to the Federal Government.

(4) The State provides for reporting of such information as the Commissioner determines and assurances satisfactory to the Commissioner that it will vigorously enforce violations of applicable requirements.

(5) Such other requirements as the Commissioner may specify.

(c) CEASING OPERATION.—

(1) IN GENERAL.—A State-based Health Insurance Exchange may, at the option of each State involved, and only after providing timely and reasonable notice to the Commissioner, cease operation as such an Exchange, in which case the Health Insurance Exchange shall operate, instead of such State-

based Health Insurance Exchange, with respect to such State (or States).

(2) TERMINATION; HEALTH INSURANCE EXCHANGE RESUMPTION OF FUNCTIONS.—The Commissioner may terminate the approval (for some or all functions) of a State-based Health Insurance Exchange under this section if the Commissioner determines that such Exchange no longer meets the requirements of subsection (b) or is no longer capable of carrying out such functions in accordance with the requirements of this subtitle. In lieu of terminating such approval, the Commissioner may temporarily assume some or all functions of the State-based Health Insurance Exchange until such time as the Commissioner determines the State-based Health Insurance Exchange meets such requirements of subsection (b) and is capable of carrying out such functions in accordance with the requirements of this subtitle.

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

(d) RETENTION OF AUTHORITY.—

(1) AUTHORITY RETAINED.—Enforcement authorities of the Commissioner shall be retained by the Commissioner.

(2) DISCRETION TO RETAIN ADDITIONAL AUTHORITY.—The Commissioner may specify functions of the Health Insurance Exchange that—

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

(B) may be performed by the Commissioner and by such a State-based Health Insurance Exchange.

(e) REFERENCES.—In the case of a State-based Health Insurance Exchange, except as the Commissioner may otherwise specify under subsection (d), any references in this subtitle to the Health Insurance Exchange or to the Commissioner in the area in which the State-based Health Insurance Exchange operates shall be deemed a reference to the State-based Health Insurance Exchange and the head of such Exchange, respectively.

(f) FUNDING.—In the case of a State-based Health Insurance Exchange, there shall be assistance provided for the operation of such Exchange in the form of a matching grant with a State share of expenditures required.

Subtitle B—Public Health Insurance Option

SEC. 221. ESTABLISHMENT AND ADMINISTRATION OF A PUBLIC HEALTH INSURANCE OPTION AS AN EXCHANGE-QUALIFIED HEALTH BENEFITS PLAN.

(a) ESTABLISHMENT.—For years beginning with Y1, the Secretary of Health and Human Services (in this subtitle referred to as the ''Secretary'') shall provide for the offering of an Exchange-participating health benefits plan (in this division referred to as the ''public health insurance option'') that ensures choice, competition, and stability of affordable, high quality coverage throughout the United States in accordance with this subtitle. In designing the option, the Secretary's primary responsibility is to create a low-cost plan without comprimising quality or access to care.

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

(1) EXCLUSIVE TO THE EXCHANGE.—The public health insurance option shall only be made available through the Health Insurance Exchange.

(2) ENSURING A LEVEL PLAYING FIELD.—Consistent with this subtitle, the public health insurance option shall comply with requirements that are ap-

plicable under this title to an Exchange-participating health benefits plan, including requirements related to benefits, benefit levels, provider networks, notices, consumer protections, and cost sharing.

(3) PROVISION OF BENEFIT LEVELS.—The public health insurance option—

(A) shall offer basic, enhanced, and premium plans; and

(B) may offer premium-plus plans.

(c) ADMINISTRATIVE CONTRACTING.—The Secretary may enter into contracts for the purpose of performing administrative functions (including functions described in subsection (a)(4) of section 1874A of the Social Security Act) with respect to the public health insurance option in the same manner as the Secretary may enter into contracts under subsection (a)(1) of such section. The Secretary has the same authority with respect to the public health insurance option as the Secretary has under subsections (a)(1) and (b) of section 1874A of the Social Security Act with respect to title XVIII of such Act. Contracts under this subsection shall not involve the transfer of insurance risk to such entity.

(d) OMBUDSMAN.—The Secretary shall establish an office of the ombudsman for the public health insurance option which shall have duties with respect to the public

health insurance option similar to the duties of the Medicare Beneficiary Ombudsman under section 1808(c)(2) of the Social Security Act.

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

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

(g) ACCESS TO FEDERAL COURTS.—The provisions of Medicare (and related provisions of title II of the Social Security Act) relating to access of Medicare beneficiaries to Federal courts for the enforcement of rights under Medicare, including with respect to amounts in controversy, shall apply to the public health insurance option and individuals enrolled under such option under this title in the same manner as such provisions apply to Medicare and Medicare beneficiaries.

SEC. 222. PREMIUMS AND FINANCING.

(a) ESTABLISHMENT OF PREMIUMS.—

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

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

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

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

(ii) administrative costs related to operating the public health insurance option.

(2) CONTINGENCY MARGIN.—In establishing premium rates under paragraph (1), the Secretary shall include an appropriate amount for a contingency margin.

(b) ACCOUNT.—

(1) ESTABLISHMENT.—There is established in the Treasury of the United States an Account for the receipts and disbursements attributable to the operation of the public health insurance option, including the start-up funding under paragraph (2). Section 1854(g) of the Social Security Act shall apply to receipts described in the previous sentence

in the same manner as such section applies to payments or premiums described in such section.

(2) START-UP FUNDING.—

(A) IN GENERAL.—In order to provide for the establishment of the public health insurance option there is hereby appropriated to the Secretary, out of any funds in the Treasury not otherwise appropriated, $2,000,000,000. In order to provide for initial claims reserves before the collection of premiums, there is hereby appropriated to the Secretary, out of any funds in the Treasury not otherwise appropriated, such sums as necessary to cover 90 days worth of claims reserves based on projected enrollment.

(B) AMORTIZATION OF START-UP FUNDING.—The Secretary shall provide for the repayment of the startup funding provided under subparagraph (A) to the Treasury in an amortized manner over the 10-year period beginning with Y1.

(C) LIMITATION ON FUNDING.—Nothing in this section shall be construed as authorizing any additional appropriations to the Account, other than such amounts as are otherwise pro-

vided with respect to other Exchange-participating health benefits plans.

SEC. 223. PAYMENT RATES FOR ITEMS AND SERVICES.

(a) RATES ESTABLISHED BY SECRETARY.—

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

(2) INITIAL PAYMENT RULES.—

(A) IN GENERAL.—Except as provided in subparagraph (B) and subsection (b)(1), during Y1, Y2, and Y3, the Secretary shall base the payment rates under this section for services and providers described in paragraph (1) on the payment rates for similar services and providers under parts A and B of Medicare.

(B) EXCEPTIONS.—

(i) PRACTITIONERS' SERVICES.—Payment rates for practitioners' services otherwise established under the fee schedule under section 1848 of the Social Security Act shall be applied without regard to the provisions under subsection (f) of such section and the update under subsection

(d)(4) under such section for a year as applied under this paragraph shall be not less than 1 percent.

(ii) ADJUSTMENTS.—The Secretary may determine the extent to which Medicare adjustments applicable to base payment rates under parts A and B of Medicare shall apply under this subtitle.

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

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

(b) INCENTIVES FOR PARTICIPATING PROVIDERS.—

(1) INITIAL INCENTIVE PERIOD.—

(A) IN GENERAL.—The Secretary shall provide, in the case of services described in subparagraph (B) furnished during Y1, Y2, and Y3, for payment rates that are 5 percent greater than the rates established under subsection (a).

(B) SERVICES DESCRIBED.—The services described in this subparagraph are items and professional services, under the public health insurance option by a physician or other health care practitioner who participates in both Medicare and the public health insurance option.

(C) SPECIAL RULES.—A pediatrician and any other health care practitioner who is a type of practitioner that does not typically participate in Medicare (as determined by the Secretary) shall also be eligible for the increased payment rates under subparagraph (A).

(2) SUBSEQUENT PERIODS.— Beginning with Y4 and for subsequent years, the Secretary shall continue to use an administrative process to set such rates in order to promote payment accuracy, to ensure adequate beneficiary access to providers, and to promote affordablility and the efficient delivery of medical care consistent with section 221(a). Such rates shall not be set at levels expected to increase overall medical costs under the option beyond what would be expected if the process under subsection (a)(2) and paragraph (1) of this subsection were continued.

(3) ESTABLISHMENT OF A PROVIDER NETWORK.—Health care providers participating under Medicare are participating providers in the public health insurance option unless they opt out in a process established by the Secretary.

(c) ADMINISTRATIVE PROCESS FOR SETTING RATES.—Chapter 5 of title 5, United States Code shall apply to the process for the initial establishment of payment rates under this section but not to the specific methodology for establishing such rates or the calculation of such rates.

(d) CONSTRUCTION.—Nothing in this subtitle shall be construed as limiting the Secretary's authority to correct for payments that are excessive or deficient, taking into account the provisions of section 221(a) and the amounts paid for similar health care providers and services under other Exchange-participating health benefits plans.

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

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

odology established under this section or under section 224.

SEC. 224. MODERNIZED PAYMENT INITIATIVES AND DELIVERY SYSTEM REFORM.

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

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

(1) seeks to—

(A) improve health outcomes;

(B) reduce health disparities (including racial, ethnic, and other disparities);

(C) provide efficent and affordable care;

(D) address geographic variation in the provision of health services; or

(E) prevent or manage chronic illness; and

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

(c) ENCOURAGING THE USE OF HIGH VALUE SERVICES.—To the extent allowed by the benefit standards applied to all Exchange-participating health benefits plans, the public health insurance option may modify cost sharing and payment rates to encourage the use of services that promote health and value.

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

SEC. 225. PROVIDER PARTICIPATION.

(a) IN GENERAL.—The Secretary shall establish conditions of participation for health care providers under the public health insurance option.

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

(c) PAYMENT TERMS FOR PROVIDERS.—

(1) PHYSICIANS.—The Secretary shall provide for the annual participation of physicians under the public health insurance option, for which payment may be made for services furnished during the year, in one of 2 classes:

(A) PREFERRED PHYSICIANS.—Those physicians who agree to accept the payment rate established under section 223 (without regard to cost-sharing) as the payment in full.

(B) PARTICIPATING, NON-PREFERRED PHYSICIANS.—Those physicians who agree not to impose charges (in relation to the payment rate described in section 223 for such physicians) that exceed the ratio permitted under section 1848(g)(2)(C) of the Social Security Act.

(2) OTHER PROVIDERS.—The Secretary shall provide for the participation (on an annual or other basis specified by the Secretary) of health care providers (other than physicians) under the public health insurance option under which payment shall only be available if the provider agrees to accept the payment rate established under section 223 (without regard to cost-sharing) as the payment in full.

(d) EXCLUSION OF CERTAIN PROVIDERS.—The Secretary shall exclude from participation under the public health insurance option a health care provider that is excluded from participation in a Federal health care program (as defined in section 1128B(f) of the Social Security Act).

SEC. 226. APPLICATION OF FRAUD AND ABUSE PROVISIONS.

Provisions of law (other than criminal law provisions) identified by the Secretary by regulation, in consultation with the Inspector General of the Department of Health and Human Services, that impose sanctions with respect to waste, fraud, and abuse under Medicare, such as the False Claims Act (31 U.S.C. 3729 et seq.), shall also apply to the public health insurance option.

Subtitle C—Individual Affordability Credits

SEC. 241. AVAILABILITY THROUGH HEALTH INSURANCE EXCHANGE.

(a) IN GENERAL.—Subject to the succeeding provisions of this subtitle, in the case of an affordable credit eligible individual enrolled in an Exchange-participating health benefits plan—

(1) the individual shall be eligible for, in accordance with this subtitle, affordability credits consisting of—

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

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

(2) the Commissioner shall pay the QHBP offering entity that offers such plan from the Health Insurance Exchange Trust Fund the aggregate amount of affordability credits for all affordable credit eligible individuals enrolled in such plan.

(b) APPLICATION.—

(1) IN GENERAL.—An Exchange eligible individual may apply to the Commissioner through the Health Insurance Exchange or through another entity under an arrangement made with the Commissioner, in a form and manner specified by the Commissioner. The Commissioner through the Health Insurance Exchange or through another public entity under an arrangement made with the Commis-

sioner shall make a determination as to eligibility of an individual for affordability credits under this subtitle.The Commissioner shall establish a process whereby, on the basis of information otherwise available, individuals may be deemed to be affordable credit eligible individuals. In carrying this subtitle, the Commissioner shall establish effective methods that ensure that individuals with limited English proficiency are able to apply for affordability credits.

(2) USE OF STATE MEDICAID AGENCIES.—If the Commissioner determines that a State Medicaid agency has the capacity to make a determination of eligibility for affordability credits under this subtitle and under the same standards as used by the Commissioner, under the Medicaid memorandum of understanding (as defined in section 205(c)(4))—

(A) the State Medicaid agency is authorized to conduct such determinations for any Exchange-eligible individual who requests such a determination; and

(B) the Commissioner shall reimburse the State Medicaid agency for the costs of conducting such determinations.

(3) MEDICAID SCREEN AND ENROLL OBLIGATION.—In the case of an application made under

paragraph (1), there shall be a determination of whether the individual is a Medicaid-eligible individual. If the individual is determined to be so eligible, the Commissioner, through the Medicaid memorandum of understanding, shall provide for the enrollment of the individual under the State Medicaid plan in accordance with the Medicaid memorandum of understanding. In the case of such an enrollment, the State shall provide for the same periodic redetermination of eligibility under Medicaid as would otherwise apply if the individual had directly applied for medical assistance to the State Medicaid agency.

(c) USE OF AFFORDABILITY CREDITS.—

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

(2) FLEXIBILITY IN PLAN ENROLLMENT AUTHORIZED.—Beginning with Y3, the Commissioner shall establish a process to allow an affordability credit to be used for enrollees in enhanced or premium plans. In the case of an affordable credit eligible individual who enrolls in an enhanced or premium plan, the individual shall be responsible for any difference between the premium for such plan

and the affordable credit amount otherwise applicable if the individual had enrolled in a basic plan.

(d) ACCESS TO DATA.—In carrying out this subtitle, the Commissioner shall request from the Secretary of the Treasury consistent with section 6103 of the Internal Revenue Code of 1986 such information as may be required to carry out this subtitle.

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

SEC. 242. AFFORDABLE CREDIT ELIGIBLE INDIVIDUAL.

(a) DEFINITION.—

(1) IN GENERAL.—For purposes of this division, the term ''affordable credit eligible individual'' means, subject to subsection (b), an individual who is lawfully present in a State in the United States (other than as a nonimmigrant described in a subparagraph (excluding subparagraphs (K), (T), (U), and (V)) of section 101(a)(15) of the Immigration and Nationality Act)—

(A) who is enrolled under an Exchange-participating health benefits plan and is not enrolled under such plan as an employee (or dependent of an employee) through an employer

qualified health benefits plan that meets the requirements of section 312;

(B) with family income below 400 percent of the Federal poverty level for a family of the size involved; and

(C) who is not a Medicaid eligible individual, other than an individual described in section 202(d)(3) or an individual during a transition period under section 202(d)(4)(B)(ii).

(2) TREATMENT OF FAMILY.—Except as the Commissioner may otherwise provide, members of the same family who are affordable credit eligible individuals shall be treated as a single affordable credit individual eligible for the applicable credit for such a family under this subtitle.

(b) LIMITATIONS ON EMPLOYEE AND DEPENDENT DISQUALIFICATION.—

(1) IN GENERAL.—Subject to paragraph (2), the term ''affordable credit eligible individual'' does not include a full-time employee of an employer if the employer offers the employee coverage (for the employee and dependents) as a full-time employee under a group health plan if the coverage and employer contribution under the plan meet the requirements of section 312.

(2) EXCEPTIONS.—

(A) FOR CERTAIN FAMILY CIRCUMSTANCES.—The Commissioner shall establish such exceptions and special rules in the case described in paragraph (1) as may be appropriate in the case of a divorced or separated individual or such a dependent of an employee who would otherwise be an affordable credit eligible individual.

(B) FOR UNAFFORDABLE EMPLOYER COVERAGE.—Beginning in Y2, in the case of full-time employees for which the cost of the employee premium for coverage under a group health plan would exceed 11 percent of current family income (determined by the Commissioner on the basis of verifiable documentation and without regard to section 245), paragraph (1) shall not apply.

(c) INCOME DEFINED.—

(1) IN GENERAL.—In this title, the term ''income'' means modified adjusted gross income (as defined in section 59B of the Internal Revenue Code of 1986).

(2) STUDY OF INCOME DISREGARDS.—The Commissioner shall conduct a study that examines

the application of income disregards for purposes of this subtitle. Not later than the first day of Y2, the Commissioner shall submit to Congress a report on such study and shall include such recommendations as the Commissioner determines appropriate.

(d) CLARIFICATION OF TREATMENT OF AFFORDABILITY CREDITS.—Affordabilty credits under this subtitle shall not be treated, for purposes of title IV of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, to be a benefit provided under section 403 of such title.

SEC. 243. AFFORDABLE PREMIUM CREDIT.

(a) IN GENERAL.—The affordability premium credit under this section for an affordable credit eligible individual enrolled in an Exchange-participating health benefits plan is in an amount equal to the amount (if any) by which the premium for the plan (or, if less, the reference premium amount specified in subsection (c)), exceeds the affordable premium amount specified in subsection (b) for the individual.

(b) AFFORDABLE PREMIUM AMOUNT.—

(1) IN GENERAL.—The affordable premium amount specified in this subsection for an individual for monthly premium in a plan year shall be equal to 1/12 of the product of—

(A) the premium percentage limit specified in paragraph (2) for the individual based upon the individual's family income for the plan year; and

(B) the individual's family income for such plan year.

(2) PREMIUM PERCENTAGE LIMITS BASED ON TABLE.—The Commissioner shall establish premium percentage limits so that for individuals whose family income is within an income tier specified in the table in subsection (d) such percentage limits shall increase, on a sliding scale in a linear manner, from the initial premium percentage to the final premium percentage specified in such table for such income tier.

(c) REFERENCE PREMIUM AMOUNT.—The reference premium amount specified in this subsection for a plan year for an individual in a premium rating area is equal to the average premium for the 3 basic plans in the area for the plan year with the lowest premium levels. In computing such amount the Commissioner may exclude plans with extremely limited enrollments.

(d) TABLE OF PREMIUM PERCENTAGE LIMITS AND ACTUARIAL VALUE PERCENTAGES BASED ON INCOME TIER.—

(1) IN GENERAL.—For purposes of this subtitle, the table specified in this subsection is as follows:

In the case of family 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—
133% through 150%	1.5%	3%	97%
150% through 200%	3%	5%	93%
200% through 250%	5%	7%	85%
250% through 300%	7%	9%	78%
300% through 350%	9%	10%	72%
350% through 400%	10%	11%	70%

(2) SPECIAL RULES.—For purposes of applying the table under paragraph (1)—

(A) FOR LOWEST LEVEL OF INCOME.—In the case of an individual with income that does not exceed 133 percent of FPL, the individual shall be considered to have income that is 133% of FPL.

(B) APPLICATION OF HIGHER ACTUARIAL VALUE PERCENTAGE AT TIER TRANSITION POINTS.—If two actuarial value percentages may be determined with respect to an individual, the actuarial value percentage shall be the higher of such percentages.

SEC. 244. AFFORDABILITY COST-SHARING CREDIT.

(a) IN GENERAL.—The affordability cost-sharing credit under this section for an affordable credit eligible individual enrolled in an Exchange-participating health

benefits plan is in the form of the cost-sharing reduction described in subsection (b) provided under this section for the income tier in which the individual is classified based on the individual's family income.

(b) COST-SHARING REDUCTIONS.—The Commissioner shall specify a reduction in cost-sharing amounts and the annual limitation on cost-sharing specified in section 122(c)(2)(B) under a basic plan for each income tier specified in the table under section 243(d), with respect to a year, in a manner so that, as estimated by the Commissioner, the actuarial value of the coverage with such reduced cost-sharing amounts (and the reduced annual cost-sharing limit) is equal to the actuarial value percentage (specified in the table under section 243(d) for the income tier involved) of the full actuarial value if there were no cost-sharing imposed under the plan.

(c) DETERMINATION AND PAYMENT OF COST-SHARING AFFORDABILITY CREDIT.—In the case of an affordable credit eligible individual in a tier enrolled in an Exchange-participating health benefits plan offered by a QHBP offering entity, the Commissioner shall provide for payment to the offering entity of an amount equivalent to the increased actuarial value of the benefits under the plan provided under section 203(c)(2)(B) resulting from the reduction in cost-sharing described in subsection (b).

SEC. 245. INCOME DETERMINATIONS.

(a) IN GENERAL.—In applying this subtitle for an affordability credit for an individual for a plan year, the individual's income shall be the income (as defined in section 242(c)) for the individual for the most recent taxable year (as determined in accordance with rules of the Commissioner). The Federal poverty level applied shall be such level in effect as of the date of the application.

(b) PROGRAM INTEGRITY; INCOME VERIFICATION PROCEDURES.—

(1) PROGRAM INTEGRITY.—The Commissioner shall take such steps as may be appropriate to ensure the accuracy of determinations and redeterminations under this subtitle.

(2) INCOME VERIFICATION.—

(A) IN GENERAL.—Upon an initial application of an individual for an affordability credit under this subtitle (or in applying section 242(b)) or upon an application for a change in the affordability credit based upon a significant change in family income described in subparagraph (A)—

(i) the Commissioner shall request from the Secretary of the Treasury the disclosure to the Commissioner of such information as may be permitted to verify the

information contained in such application; and

(ii) the Commissioner shall use the information so disclosed to verify such information.

(B) ALTERNATIVE PROCEDURES.—The Commissioner shall establish procedures for the verification of income for purposes of this subtitle if no income tax return is available for the most recent completed tax year.

(c) SPECIAL RULES.—

(1) CHANGES IN INCOME AS A PERCENT OF FPL.—In the case that an individual's income (expressed as a percentage of the Federal poverty level for a family of the size involved) for a plan year is expected (in a manner specified by the Commissioner) to be significantly different from the income (as so expressed) used under subsection (a), the Commissioner shall establish rules requiring an individual to report, consistent with the mechanism established under paragraph (2), significant changes in such income (including a significant change in family composition) to the Commissioner and requiring the substitution of such income for the income otherwise applicable.

(2) REPORTING OF SIGNIFICANT CHANGES IN INCOME.—The Commissioner shall establish rules under which an individual determined to be an affordable credit eligible individual would be required to inform the Commissioner when there is a significant change in the family income of the individual (expressed as a percentage of the FPL for a family of the size involved) and of the information regarding such change. Such mechanism shall provide for guidelines that specify the circumstances that qualify as a significant change, the verifiable information required to document such a change, and the process for submission of such information. If the Commissioner receives new information from an individual regarding the family income of the individual,the Commissioner shall provide for a redetermination of the individual's eligibility to be an affordable credit eligible individual.

(3) TRANSITION FOR CHIP.—In the case of a child described in section 202(d)(2), the Commissioner shall establish rules under which the family income of the child is deemed to be no greater than the family income of the child as most recently determined before Y1 by the State under title XXI of the Social Security Act.

(4) STUDY OF GEOGRAPHIC VARIATION IN APPLICATION OF FPL.—The Commissioner shall examine the feasibility and implication of adjusting the application of the Federal poverty level under this subtitle for different geographic areas so as to reflect the variations in cost-of-living among different areas within the United States. If the Commissioner determines that an adjustment is feasible, the study should include a methodology to make such an adjustment. Not later than the first day of Y2, the Commissioner shall submit to Congress a report on such study and shall include such recommendations as the Commissioner determines appropriate.

(d) PENALTIES FOR MISREPRESENTATION.—In the case of an individual intentionally misrepresents family income or the individual fails (without regard to intent) to disclose to the Commissioner a significant change in family income under subsection (c) in a manner that results in the individual becoming an affordable credit eligible individual when the individual is not or in the amount of the affordability credit exceeding the correct amount—

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

(2) in the case of such an intentional misrepresentation or other egregious circumstances specified

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

SEC. 246. NO FEDERAL PAYMENT FOR UNDOCUMENTED ALIENS.

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

TITLE III—SHARED RESPONSIBILITY

Subtitle A—Individual Responsibility

SEC. 301. INDIVIDUAL RESPONSIBILITY.

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

Subtitle B—Employer Responsibility

PART 1—HEALTH COVERAGE PARTICIPATION REQUIREMENTS

SEC. 311. HEALTH COVERAGE PARTICIPATION REQUIREMENTS.

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

(1) OFFER OF COVERAGE.—The employer offers each employee individual and family coverage

under a qualified health benefits plan (or under a current employment-based health plan (within the meaning of section 102(b))) in accordance with section 312.

(2) CONTRIBUTION TOWARDS COVERAGE.—If an employee accepts such offer of coverage, the employer makes timely contributions towards such coverage in accordance with section 312.

(3) CONTRIBUTION IN LIEU OF COVERAGE.—Beginning with Y2, if an employee declines such offer but otherwise obtains coverage in an Exchange-participating health benefits plan (other than by reason of being covered by family coverage as a spouse or dependent of the primary insured), the employer shall make a timely contribution to the Health Insurance Exchange with respect to each such employee in accordance with section 313.

SEC. 312. EMPLOYER RESPONSIBILITY TO CONTRIBUTE TOWARDS EMPLOYEE AND DEPENDENT COVERAGE.

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

(1) OFFERING OF COVERAGE.—The employer offers the coverage described in section 311(1) either

through an Exchange-participating health benefits plan or other than through such a plan.

(2) EMPLOYER REQUIRED CONTRIBUTION.—The employer timely pays to the issuer of such coverage an amount not less than the employer required contribution specified in subsection (b) for such coverage.

(3) PROVISION OF INFORMATION.—The employer provides the Health Choices Commissioner, the Secretary of Labor, the Secretary of Health and Human Services, and the Secretary of the Treasury, as applicable, with such information as the Commissioner may require to ascertain compliance with the requirements of this section.

(4) AUTOENROLLMENT OF EMPLOYEES.—The employer provides for autoenrollment of the employee in accordance with subsection (c).

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

(1) FULL-TIME EMPLOYEES.—The minimum employer contribution described in this subsection for coverage of a full-time employee (and, if any, the employee's spouse and qualifying children (as defined in section 152(c) of the Internal Revenue Code

of 1986) under a qualified health benefits plan (or current employment-based health plan) is equal to—

(A) in case of individual coverage, not less than 72.5 percent of the applicable premium (as defined in section 4980B(f)(4) of such Code, subject to paragraph (2)) of the lowest cost plan offered by the employer that is a qualified health benefits plan (or is such current employment-based health plan); and

(B) in the case of family coverage which includes coverage of such spouse and children, not less 65 percent of such applicable premium of such lowest cost plan.

(2) APPLICABLE PREMIUM FOR EXCHANGE COVERAGE.—In this subtitle, the amount of the applicable premium of the lowest cost plan with respect to coverage of an employee under an Exchange-participating health benefits plan is the reference premium amount under section 243(c) for individual coverage (or, if elected, family coverage) for the premium rating area in which the individual or family resides.

(3) MINIMUM EMPLOYER CONTRIBUTION FOR EMPLOYEES OTHER THAN FULL-TIME EMPLOYEES.—In the case of coverage for an employee who is not a full-time employee, the amount of the min-

imum employer contribution under this subsection shall be a proportion (as determined in accordance with rules of the Health Choices Commissioner, the Secretary of Labor, the Secretary of Health and Human Services, and the Secretary of the Treasury, as applicable) of the minimum employer contribution under this subsection with respect to a full-time employee that reflects the proportion of—

(A) the average weekly hours of employment of the employee by the employer, to

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

(4) SALARY REDUCTIONS NOT TREATED AS EMPLOYER CONTRIBUTIONS.—For purposes of this section, any contribution on behalf of an employee with respect to which there is a corresponding reduction in the compensation of the employee shall not be treated as an amount paid by the employer.

(c) AUTOMATIC ENROLLMENT FOR EMPLOYER SPONSORED HEALTH BENEFITS.—

(1) IN GENERAL.—The requirement of this subsection with respect to an employer and an employee is that the employer automatically enroll suchs employee into the employment-based health benefits

plan for individual coverage under the plan option with the lowest applicable employee premium.

(2) OPT-OUT.—In no case may an employer automatically enroll an employee in a plan under paragraph (1) if such employee makes an affirmative election to opt out of such plan or to elect coverage under an employment-based health benefits plan offered by such employer. An employer shall provide an employee with a 30-day period to make such an affirmative election before the employer may automatically enroll the employee in such a plan.

(3) NOTICE REQUIREMENTS.—

(A) IN GENERAL.—Each employer described in paragraph (1) who automatically enrolls an employee into a plan as described in such paragraph shall provide the employees, within a reasonable period before the beginning of each plan year (or, in the case of new employees, within a reasonable period before the end of the enrollment period for such a new employee), written notice of the employees' rights and obligations relating to the automatic enrollment requirement under such paragraph. Such notice must be comprehensive and understood

by the average employee to whom the automatic enrollment requirement applies.

(B) INCLUSION OF SPECIFIC INFORMATION.—The written notice under subparagraph (A) must explain an employee's right to opt out of being automatically enrolled in a plan and in the case that more than one level of benefits or employee premium level is offered by the employer involved, the notice must explain which level of benefits and employee premium level the employee will be automatically enrolled in the absence of an affirmative election by the employee.

SEC. 313. EMPLOYER CONTRIBUTIONS IN LIEU OF COVERAGE.

(a) IN GENERAK.—A contribution is made in accordance with this section with respect to an employee if such contribution is equal to an amount equal to 8 percent of the average wages paid by the employer during the period of enrollment (determined by taking into account all employees of the employer and in such manner as the Commissioner provides, including rules providing for the appropriate aggregation of related employers). Any such contribution—

(1) shall be paid to the Health Choices Commissioner for deposit into the Health Insurance Exchange Trust Fund, and

(2) shall not be applied against the premium of the employee under the Exchange-participating health benefits plan in which the employee is enrolled.

(b) SPECIAL RULES FOR SMALL EMPLOYERS.—

(1) IN GENERAL.—In the case of any employer who is a small employer for any calendar year, subsection (a) shall be applied by substituting the applicable percentage determined in accordance with the following table for ''8 percent'':

If the annual payroll of such employer for the preceding calendar year:	**The applicable percentage is:**
Does not exceed $250,000	0 percent
Exceeds $250,000, but does not exceed $300,000	2 percent
Exceeds $300,000, but does not exceed $350,000	4 percent
Exceeds $350,000, but does not exceed $400,000	6 percent

(2) SMALL EMPLOYER.—For purposes of this subsection, the term ''small employer'' means any employer for any calendar year if the annual payroll of such employer for the preceding calendar year does not exceed $400,000.

(3) ANNUAL PAYROLL.—For purposes of this paragraph, the term ''annual payroll'' means, with respect to any employer for any calendar year, the

aggregate wages paid by the employer during such calendar year.

(4) AGGREGATION RULES.—Related employers and predecessors shall be treated as a single employer for purposes of this subsection.

SEC. 314. AUTHORITY RELATED TO IMPROPER STEERING.

The Health Choices Commissioner (in coordination with the Secretary of Labor, the Secretary of Health and Human Services, and the Secretary of the Treasury) shall have authority to set standards for determining whether employers or insurers are undertaking any actions to affect the risk pool within the Health Insurance Exchange by inducing individuals to decline coverage under a qualified health benefits plan (or current employment-based health plan (within the meaning of section 102(b)) offered by the employer and instead to enroll in an Exchange-participating health benefits plan. An employer violating such standards shall be treated as not meeting the requirements of this section.

PART 2—SATISFACTION OF HEALTH COVERAGE PARTICIPATION REQUIREMENTS

SEC. 321. SATISFACTION OF HEALTH COVERAGE PARTICIPATION REQUIREMENTS UNDER THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974.

(a) IN GENERAL.—Subtitle B of title I of the Employee Retirement Income Security Act of 1974 is amended by adding at the end the following new part:

"**PART 8—NATIONAL HEALTH COVERAGE PARTICIPATION REQUIREMENTS**

"**SEC. 801. ELECTION OF EMPLOYER TO BE SUBJECT TO NATIONAL HEALTH COVERAGE PARTICIPATION REQUIREMENTS.**

"(a) IN GENERAL.—An employer may make an election with the Secretary to be subject to the health coverage participation requirements.

"(b) TIME AND MANNER.—An election under subsection (a) may be made at such time and in such form and manner as the Secretary may prescribe.

"**SEC. 802. TREATMENT OF COVERAGE RESULTING FROM ELECTION.**

"(a) IN GENERAL.—If an employer makes an election to the Secretary under section 801—

"(1) such election shall be treated as the establishment and maintenance of a group health plan (as

defined in section 733(a)) for purposes of this title, subject to section 151 of the America's Affordable Health Choices Act of 2009, and

''(2) the health coverage participation requirements shall be deemed to be included as terms and conditions of such plan.

''(b) PERIODIC INVESTIGATIONS TO DISCOVER NONCOMPLIANCE.—The Secretary shall regularly audit a representative sampling of employers and group health plans and conduct investigations and other activities under section 504 with respect to such sampling of plans so as to discover noncompliance with the health coverage participation requirements in connection with such plans. The Secretary shall communicate findings of noncompliance made by the Secretary under this subsection to the Secretary of the Treasury and the Health Choices Commissioner. The Secretary shall take such timely enforcement action as appropriate to achieve compliance.

''**SEC. 803. HEALTH COVERAGE PARTICIPATION REQUIREMENTS.**

''For purposes of this part, the term 'health coverage participation requirements' means the requirements of part 1 of subtitle B of title III of division A of America's Affordable Health Choices Act of 2009 (as in effect on the date of the enactment of such Act).

"**SEC. 804. RULES FOR APPLYING REQUIREMENTS.**

"(a) AFFILIATED GROUPS.—In the case of any employer which is part of a group of employers who are treated as a single employer under subsection (b), (c), (m), or (o) of section 414 of the Internal Revenue Code of 1986, the election under section 801 shall be made by such employer as the Secretary may provide. Any such election, once made, shall apply to all members of such group.

"(b) SEPARATE ELECTIONS.—Under regulations prescribed by the Secretary, separate elections may be made under section 801 with respect to—

"(1) separate lines of business, and

"(2) full-time employees and employees who are not full-time employees.

"**SEC. 805. TERMINATION OF ELECTION IN CASES OF SUBSTANTIAL NONCOMPLIANCE.**

"The Secretary may terminate the election of any employer under section 801 if the Secretary (in coordination with the Health Choices Commissioner) determines that such employer is in substantial noncompliance with the health coverage participation requirements and shall refer any such determination to the Secretary of the Treasury as appropriate.

"**SEC. 806. REGULATIONS.**

"The Secretary may promulgate such regulations as may be necessary or appropriate to carry out the provi-

sions of this part, in accordance with section 324(a) of the America's Affordable Health Choices Act of 2009. The Secretary may promulgate any interim final rules as the Secretary determines are appropriate to carry out this part.''.

(b) ENFORCEMENT OF HEALTH COVERAGE PARTICIPATION REQUIREMENTS.—Section 502 of such Act (29 U.S.C. 1132) is amended—

(1) in subsection (a)(6), by striking ''paragraph'' and all that follows through ''subsection (c)'' and inserting ''paragraph (2), (4), (5), (6), (7), (8), (9), (10), or (11) of subsection (c)''; and

(2) in subsection (c), by redesignating the second paragraph (10) as paragraph (12) and by inserting after the first paragraph (10) the following new paragraph:

''(11) HEALTH COVERAGE PARTICIPATION REQUIREMENTS.—

''(A) CIVIL PENALTIES.—In the case of any employer who fails (during any period with respect to which an election under section 801(a) is in effect) to satisfy the health coverage participation requirements with respect to any employee, the Secretary may assess a civil penalty against the employer of $100 for each

day in the period beginning on the date such failure first occurs and ending on the date such failure is corrected.

"(B) HEALTH COVERAGE PARTICIPATION REQUIREMENTS.—For purposes of this paragraph, the term 'health coverage participation requirements' has the meaning provided in section 803.

"(C) LIMITATIONS ON AMOUNT OF PENALTY.—

"(i) PENALTY NOT TO APPLY WHERE FAILURE NOT DISCOVERED EXERCISING REASONABLE DILIGENCE.—No penalty shall be assessed under subparagraph (A) with respect to any failure during any period for which it is established to the satisfaction of the Secretary that the employer did not know, or exercising reasonable diligence would not have known, that such failure existed.

"(ii) PENALTY NOT TO APPLY TO FAILURES CORRECTED WITHIN 30 DAYS.—No penalty shall be assessed under subparagraph (A) with respect to any failure if—

''(I) such failure was due to reasonable cause and not to willful neglect, and

''(II) such failure is corrected during the 30-day period beginning on the 1st date that the employer knew, or exercising reasonable diligence would have known, that such failure existed.

''(iii) OVERALL LIMITATION FOR UNINTENTIONAL FAILURES.—In the case of failures which are due to reasonable cause and not to willful neglect, the penalty assessed under subparagraph (A) for failures during any 1-year period shall not exceed the amount equal to the lesser of—

''(I) 10 percent of the aggregate amount paid or incurred by the employer (or predecessor employer) during the preceding 1-year period for group health plans, or

''(II) $500,000.

''(D) ADVANCE NOTIFICATION OF FAILURE PRIOR TO ASSESSMENT.—Before a reasonable time prior to the assessment of any penalty

under this paragraph with respect to any failure by an employer, the Secretary shall inform the employer in writing of such failure and shall provide the employer information regarding efforts and procedures which may be undertaken by the employer to correct such failure.

''(E) COORDINATION WITH EXCISE TAX.—Under regulations prescribed in accordance with section 324 of the America's Affordable Health Choices Act of 2009, the Secretary and the Secretary of the Treasury shall coordinate the assessment of penalties under this section in connection with failures to satisfy health coverage participation requirements with the imposition of excise taxes on such failures under section 4980H(b) of the Internal Revenue Code of 1986 so as to avoid duplication of penalties with respect to such failures.

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

(c) CLERICAL AMENDMENTS.—The table of contents in section 1 of such Act is amended by inserting after the 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 participation requirements.
"Sec. 802. Treatment of coverage resulting from election.
"Sec. 803. Health coverage participation requirements.
"Sec. 804. Rules for applying requirements.
"Sec. 805. Termination of election in cases of substantial noncompliance.
"Sec. 806. Regulations.".

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to periods beginning after December 31, 2012.

SEC. 322. SATISFACTION OF HEALTH COVERAGE PARTICIPATION REQUIREMENTS UNDER THE INTERNAL REVENUE CODE OF 1986.

(a) FAILURE TO ELECT, OR SUBSTANTIALLY COMPLY WITH, HEALTH COVERAGE PARTICIPATION REQUIREMENTS.—For employment tax on employers who fail to elect, or substantially comply with, the health coverage participation requirements described in part 1, see section 3111(c) of the Internal Revenue Code of 1986 (as added by section 412 of this Act).

(b) OTHER FAILURES.—For excise tax on other failures of electing employers to comply with such requirements, see section 4980H of the Internal Revenue Code of 1986 (as added by section 411 of this Act).

SEC. 323. SATISFACTION OF HEALTH COVERAGE PARTICIPATION REQUIREMENTS UNDER THE PUBLIC HEALTH SERVICE ACT.

(a) IN GENERAL.—Part C of title XXVII of the Public Health Service Act is amended by adding at the end the following new section:

"**SEC. 2793. NATIONAL HEALTH COVERAGE PARTICIPATION REQUIREMENTS.**

''(a) ELECTION OF EMPLOYER TO BE SUBJECT TO NATIONAL HEALTH COVERAGE PARTICIPATION REQUIREMENTS.—

''(1) IN GENERAL.—An employer may make an election with the Secretary to be subject to the health coverage participation requirements.

''(2) TIME AND MANNER.—An election under paragraph (1) may be made at such time and in such form and manner as the Secretary may prescribe.

''(b) TREATMENT OF COVERAGE RESULTING FROM ELECTION.—

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

''(A) such election shall be treated as the establishment and maintenance of a group health plan for purposes of this title, subject to

section 151 of the America's Affordable Health Choices Act of 2009, and

''(B) the health coverage participation requirements shall be deemed to be included as terms and conditions of such plan.

''(2) PERIODIC INVESTIGATIONS TO DETERMINE COMPLIANCE WITH HEALTH COVERAGE PARTICIPATION REQUIREMENTS.—The Secretary shall regularly audit a representative sampling of employers and conduct investigations and other activities with respect to such sampling of employers so as to discover noncompliance with the health coverage participation requirements in connection with such employers (during any period with respect to which an election under subsection (a) is in effect). The Secretary shall communicate findings of noncompliance made by the Secretary under this subsection to the Secretary of the Treasury and the Health Choices Commissioner. The Secretary shall take such timely enforcement action as appropriate to achieve compliance.

''(c) HEALTH COVERAGE PARTICIPATION REQUIREMENTS.—For purposes of this section, the term 'health coverage participation requirements' means the requirements of part 1 of subtitle B of title III of division A

of the America's Affordable Health Choices Act of 2009 (as in effect on the date of the enactment of this section).

''(d) SEPARATE ELECTIONS.—Under regulations prescribed by the Secretary, separate elections may be made under subsection (a) with respect to full-time employees and employees who are not full-time employees.

''(e) TERMINATION OF ELECTION IN CASES OF SUBSTANTIAL NONCOMPLIANCE.—The Secretary may terminate the election of any employer under subsection (a) if the Secretary (in coordination with the Health Choices Commissioner) determines that such employer is in substantial noncompliance with the health coverage participation requirements and shall refer any such determination to the Secretary of the Treasury as appropriate.

''(f) ENFORCEMENT OF HEALTH COVERAGE PARTICIPATION REQUIREMENTS.—

''(1) CIVIL PENALTIES.—In the case of any employer who fails (during any period with respect to which the election under subsection (a) is in effect) to satisfy the health coverage participation requirements with respect to any employee, the Secretary may assess a civil penalty against the employer of $100 for each day in the period beginning on the date such failure first occurs and ending on the date such failure is corrected.

''(2) LIMITATIONS ON AMOUNT OF PENALTY.—

''(A) PENALTY NOT TO APPLY WHERE FAILURE NOT DISCOVERED EXERCISING REASONABLE DILIGENCE.—No penalty shall be assessed under paragraph (1) with respect to any failure during any period for which it is established to the satisfaction of the Secretary that the employer did not know, or exercising reasonable diligence would not have known, that such failure existed.

''(B) PENALTY NOT TO APPLY TO FAILURES CORRECTED WITHIN 30 DAYS.—No penalty shall be assessed under paragraph (1) with respect to any failure if—

''(i) such failure was due to reasonable cause and not to willful neglect, and

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

''(C) OVERALL LIMITATION FOR UNINTENTIONAL FAILURES.—In the case of failures which are due to reasonable cause and not to willful neglect, the penalty assessed under para-

graph (1) for failures during any 1-year period shall not exceed the amount equal to the lesser of—

''(i) 10 percent of the aggregate amount paid or incurred by the employer (or predecessor employer) during the preceding taxable year for group health plans, or

''(ii) $500,000.

''(3) ADVANCE NOTIFICATION OF FAILURE PRIOR TO ASSESSMENT.—Before a reasonable time prior to the assessment of any penalty under paragraph (1) with respect to any failure by an employer, the Secretary shall inform the employer in writing of such failure and shall provide the employer information regarding efforts and procedures which may be undertaken by the employer to correct such failure.

''(4) ACTIONS TO ENFORCE ASSESSMENTS.—The Secretary may bring a civil action in any District Court of the United States to collect any civil penalty under this subsection.

''(5) COORDINATION WITH EXCISE TAX.—Under regulations prescribed in accordance with section 324 of the America's Affordable Health Choices

Act of 2009, the Secretary and the Secretary of the Treasury shall coordinate the assessment of penalties under paragraph (1) in connection with failures to satisfy health coverage participation requirements with the imposition of excise taxes on such failures under section 4980H(b) of the Internal Revenue Code of 1986 so as to avoid duplication of penalties with respect to such failures.

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

''(g) REGULATIONS.—The Secretary may promulgate such regulations as may be necessary or appropriate to carry out the provisions of this section, in accordance with section 324(a) of the America's Affordable Health Choices Act of 2009. The Secretary may promulgate any interim final rules as the Secretary determines are appropriate to carry out this section.''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to periods beginning after December 31, 2012.

SEC. 324. ADDITIONAL RULES RELATING TO HEALTH COVERAGE PARTICIPATION REQUIREMENTS.

(a) ASSURING COORDINATION.—The officers consisting of the Secretary of Labor, the Secretary of the Treasury, the Secretary of Health and Human Services, and the Health Choices Commissioner shall ensure, through the execution of an interagency memorandum of understanding among such officers, that—

(1) regulations, rulings, and interpretations issued by such officers relating to the same matter over which two or more of such officers have responsibility under subpart B of part 6 of subtitle B of title I of the Employee Retirement Income Security Act of 1974, section 4980H of the Internal Revenue Code of 1986, and section 2793 of the Public Health Service Act are administered so as to have the same effect at all times; and

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

(b) MULTIEMPLOYER PLANS.—In the case of a group health plan that is a multiemployer plan (as defined in section 3(37) of the Employee Retirement Income Security Act of 1974), the regulations prescribed in accordance

with subsection (a) by the officers referred to in subsection (a) shall provide for the application of the health coverage participation requirements to the plan sponsor and contributing sponsors of such plan.

TITLE IV—AMENDMENTS TO INTERNAL REVENUE CODE OF 1986

Subtitle A—Shared Responsibility

PART 1—INDIVIDUAL RESPONSIBILITY

SEC. 401. TAX ON INDIVIDUALS WITHOUT ACCEPTABLE HEALTH CARE COVERAGE.

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

"**PART VIII—HEALTH CARE RELATED TAXES**

"SUBPART A. TAX ON INDIVIDUALS WITHOUT ACCEPTABLE HEALTH CARE COVERAGE.

"**Subpart A—Tax on Individuals Without Acceptable Health Care Coverage**

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

"**SEC. 59B. TAX ON INDIVIDUALS WITHOUT ACCEPTABLE HEALTH CARE COVERAGE.**

"(a) TAX IMPOSED.—In the case of any individual who does not meet the requirements of subsection (d) at any time during the taxable year, there is hereby imposed a tax equal to 2.5 percent of the excess of—

''(1) the taxpayer's modified adjusted gross income for the taxable year, over

''(2) the amount of gross income specified in section 6012(a)(1) with respect to the taxpayer.

''(b) LIMITATIONS.—

''(1) TAX LIMITED TO AVERAGE PREMIUM.—

''(A) IN GENERAL.—The tax imposed under subsection (a) with respect to any taxpayer for any taxable year shall not exceed the applicable national average premium for such taxable year.

''(B) APPLICABLE NATIONAL AVERAGE PREMIUM.—

''(i) IN GENERAL.—For purposes of subparagraph (A), the 'applicable national average premium' means, with respect to any taxable year, the average premium (as determined by the Secretary, in coordination with the Health Choices Commissioner) for self-only coverage under a basic plan which is offered in a Health Insurance Exchange for the calendar year in which such taxable year begins.

''(ii) FAILURE TO PROVIDE COVERAGE FOR MORE THAN ONE INDIVIDUAL.—In the

case of any taxpayer who fails to meet the requirements of subsection (e) with respect to more than one individual during the taxable year, clause (i) shall be applied by substituting 'family coverage' for 'self-only coverage'.

''(2) PRORATION FOR PART YEAR FAILURES.—The tax imposed under subsection (a) with respect to any taxpayer for any taxable year shall not exceed the amount which bears the same ratio to the amount of tax so imposed (determined without regard to this paragraph and after application of paragraph (1)) as—

''(A) the aggregate periods during such taxable year for which such individual failed to meet the requirements of subsection (d), bears to

''(B) the entire taxable year.

''(c) EXCEPTIONS.—

''(1) DEPENDENTS.—Subsection (a) shall not apply to any individual for any taxable year if a deduction is allowable under section 151 with respect to such individual to another taxpayer for any taxable year beginning in the same calendar year as such taxable year.

''(2) NONRESIDENT ALIENS.—Subsection (a) shall not apply to any individual who is a nonresident alien.

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

''(4) INDIVIDUALS RESIDING IN POSSESSIONS OF THE UNITED STATES.—Any individual who is a bona fide resident of any possession of the United States (as determined under section 937(a)) for any taxable year (and any qualifying child residing with such individual) shall be treated for purposes of this section as covered by acceptable coverage during such taxable year.

''(5) RELIGIOUS CONSCIENCE EXEMPTION.—

''(A) IN GENERAL.—Subsection (a) shall not apply to any individual (and any qualifying child residing with such individual) for any period if such individual has in effect an exemption which certifies that such individual is a member of a recognized religious sect or divi-

sion thereof described in section 1402(g)(1) and an adherent of established tenets or teachings of such sect or division as described in such section.

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

''(d) ACCEPTABLE COVERAGE REQUIREMENT.—

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

''(2) ACCEPTABLE COVERAGE.—For purposes of this section, the term 'acceptable coverage' means any of the following:

''(A) QUALIFIED HEALTH BENEFITS PLAN COVERAGE.—Coverage under a qualified health benefits plan (as defined in section 100(c) of the America's Affordable Health Choices Act of 2009).

''(B) GRANDFATHERED HEALTH INSURANCE COVERAGE; COVERAGE UNDER GRANDFATHERED EMPLOYMENT-BASED HEALTH PLAN.—Coverage under a grandfathered health insurance coverage (as defined in subsection (a) of section 102 of the America's Affordable Health Choices Act of 2009) or under a current employment-based health plan (within the meaning of subsection (b) of such section).

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

''(D) MEDICAID.—Coverage for medical assistance under title XIX of the Social Security Act.

''(E) MEMBERS OF THE ARMED FORCES AND DEPENDENTS (INCLUDING TRICARE).—Coverage under chapter 55 of title 10, United States Code, including similar coverage furnished under section 1781 of title 38 of such Code.

''(F) VA.—Coverage under the veteran's health care program under chapter 17 of title 38, United States Code, but only if the coverage for the individual involved is determined by the Secretary in coordination with the

Health Choices Commissioner to be not less than the level specified by the Secretary of the Treasury, in coordination with the Secretary of Veteran's Affairs and the Health Choices Commissioner, based on the individual's priority for services as provided under section 1705(a) of such title.

''(G) OTHER COVERAGE.—Such other health benefits coverage as the Secretary, in coordination with the Health Choices Commissioner, recognizes for purposes of this subsection.

''(e) OTHER DEFINITIONS AND SPECIAL RULES.—

''(1) QUALIFYING CHILD.—For purposes of this section, the term 'qualifying child' has the meaning given such term by section 152(c).

''(2) BASIC PLAN.—For purposes of this section, the term 'basic plan' has the meaning given such term under section 100(c) of the America's Affordable Health Choices Act of 2009.

''(3) HEALTH INSURANCE EXCHANGE.—For purposes of this section, the term 'Health Insurance Exchange' has the meaning given such term under section 100(c) of the America's Affordable Health Choices Act of 2009, including any State-based

health insurance exchange approved for operation under section 208 of such Act.

''(4) FAMILY COVERAGE.—For purposes of this section, the term 'family coverage' means any coverage other than self-only coverage.

''(5) MODIFIED ADJUSTED GROSS INCOME.—For purposes of this section, the term 'modified adjusted gross income' means adjusted gross income—

''(A) determined without regard to section 911, and

''(B) increased by the amount of interest received or accrued by the taxpayer during the taxable year which is exempt from tax.

''(6) NOT TREATED AS TAX IMPOSED BY THIS CHAPTER FOR CERTAIN PURPOSES.—The tax imposed under this section shall not be treated as tax imposed by this chapter for purposes of determining the amount of any credit under this chapter or for purposes of section 55.

''(f) REGULATIONS.—The Secretary shall prescribe such regulations or other guidance as may be necessary or appropriate to carry out the purposes of this section, including regulations or other guidance (developed in coordination with the Health Choices Commissioner) which provide—

''(1) exemption from the tax imposed under subsection (a) in cases of de minimis lapses of acceptable coverage, and

''(2) a process for applying for a waiver of the application of subsection (a) in cases of hardship.''.

(b) INFORMATION REPORTING.—

(1) IN GENERAL.—Subpart B of part III of subchapter A of chapter 61 of such Code is amended by inserting after section 6050W the following new section:

''**SEC. 6050X. RETURNS RELATING TO HEALTH INSURANCE COVERAGE.**

''(a) REQUIREMENT OF REPORTING.—Every person who provides acceptable coverage (as defined in section 59B(d)) to any individual during any calendar year shall, at such time as the Secretary may prescribe, make the return described in subsection (b) with respect to such individual.

''(b) FORM AND MANNER OF RETURNS.—A return is described in this subsection if such return—

''(1) is in such form as the Secretary may prescribe, and

''(2) contains—

''(A) the name, address, and TIN of the primary insured and the name of each other individual obtaining coverage under the policy,

''(B) the period for which each such individual was provided with the coverage referred to in subsection (a), and

''(C) such other information as the Secretary may require.

''(c) STATEMENTS TO BE FURNISHED TO INDIVIDUALS WITH RESPECT TO WHOM INFORMATION IS REQUIRED.—Every person required to make a return under subsection (a) shall furnish to each primary insured whose name is required to be set forth in such return a written statement showing—

''(1) the name and address of the person required to make such return and the phone number of the information contact for such person, and

''(2) the information required to be shown on the return with respect to such individual.

The written statement required under the preceding sentence shall be furnished on or before January 31 of the year following the calendar year for which the return under subsection (a) is required to be made.

''(d) COVERAGE PROVIDED BY GOVERNMENTAL UNITS.—In the case of coverage provided by any govern-

mental unit or any agency or instrumentality thereof, the officer or employee who enters into the agreement to provide such coverage (or the person appropriately designated for purposes of this section) shall make the returns and statements required by this section.''.

(2) PENALTY FOR FAILURE TO FILE.—

(A) RETURN.—Subparagraph (B) of section 6724(d)(1) of such Code is amended by striking ''or'' at the end of clause (xxii), by striking ''and'' at the end of clause (xxiii) and inserting ''or'', and by adding at the end the following new clause:

''(xxiv) section 6050X (relating to returns relating to health insurance coverage), and''.

(B) STATEMENT.—Paragraph (2) of section 6724(d) of such Code is amended by striking ''or'' at the end of subparagraph (EE), by striking the period at the end of subparagraph (FF) and inserting '', or'', and by inserting after subparagraph (FF) the following new subparagraph:

''(GG) section 6050X (relating to returns relating to health insurance coverage).''.

(c) RETURN REQUIREMENT.—Subsection (a) of section 6012 of such Code is amended by inserting after paragraph (9) the following new paragraph:

''(10) Every individual to whom section 59B(a) applies and who fails to meet the requirements of section 59B(d) with respect to such individual or any qualifying child (as defined in section 152(c)) of such individual.''.

(d) CLERICAL AMENDMENTS.—

(1) The table of parts for subchapter A of chapter 1 of the Internal Revenue Code of 1986 is amended by adding at the end the following new item:

''PART VIII. HEALTH CARE RELATED TAXES.''.

(2) The table of sections for subpart B of part III of subchapter A of chapter 61 is amended by adding at the end the following new item:

''Sec. 6050X. Returns relating to health insurance coverage.''.

(e) SECTION 15 NOT TO APPLY.—The amendment made by subsection (a) shall not be treated as a change in a rate of tax for purposes of section 15 of the Internal Revenue Code of 1986.

(f) EFFECTIVE DATE.—

(1) IN GENERAL.—The amendments made by this section shall apply to taxable years beginning after December 31, 2012.

(2) RETURNS.—The amendments made by subsection (b) shall apply to calendar years beginning after December 31, 2012.

PART 2—EMPLOYER RESPONSIBILITY

SEC. 411. ELECTION TO SATISFY HEALTH COVERAGE PARTICIPATION REQUIREMENTS.

(a) IN GENERAL.—Chapter 43 of the Internal Revenue Code of 1986 is amended by adding at the end the following new section:

"**SEC. 4980H. ELECTION WITH RESPECT TO HEALTH COVERAGE PARTICIPATION REQUIREMENTS.**

''(a) ELECTION OF EMPLOYER RESPONSIBILITY TO PROVIDE HEALTH COVERAGE.—

''(1) IN GENERAL.—Subsection (b) shall apply to any employer with respect to whom an election under paragraph (2) is in effect.

''(2) TIME AND MANNER.—An employer may make an election under this paragraph at such time and in such form and manner as the Secretary may prescribe.

''(3) AFFILIATED GROUPS.—In the case of any employer which is part of a group of employers who are treated as a single employer under subsection (b), (c), (m), or (o) of section 414, the election under paragraph (2) shall be made by such person

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

''(4) SEPARATE ELECTIONS.—Under regulations prescribed by the Secretary, separate elections may be made under paragraph (2) with respect to—

''(A) separate lines of business, and

''(B) full-time employees and employees who are not full-time employees.

''(5) TERMINATION OF ELECTION IN CASES OF SUBSTANTIAL NONCOMPLIANCE.—The Secretary may terminate the election of any employer under paragraph (2) if the Secretary (in coordination with the Health Choices Commissioner) determines that such employer is in substantial noncompliance with the health coverage participation requirements.

''(b) EXCISE TAX WITH RESPECT TO FAILURE TO MEET HEALTH COVERAGE PARTICIPATION REQUIREMENTS.—

''(1) IN GENERAL.—In the case of any employer who fails (during any period with respect to which the election under subsection (a) is in effect) to satisfy the health coverage participation requirements with respect to any employee to whom such election applies, there is hereby imposed on each such failure

with respect to each such employee a tax of $100 for each day in the period beginning on the date such failure first occurs and ending on the date such failure is corrected.

''(2) LIMITATIONS ON AMOUNT OF TAX.—

''(A) TAX NOT TO APPLY WHERE FAILURE NOT DISCOVERED EXERCISING REASONABLE DILIGENCE.—No tax shall be imposed by paragraph (1) on any failure during any period for which it is established to the satisfaction of the Secretary that the employer neither knew, nor exercising reasonable diligence would have known, that such failure existed.

''(B) TAX NOT TO APPLY TO FAILURES CORRECTED WITHIN 30 DAYS.—No tax shall be imposed by paragraph (1) on any failure if—

''(i) such failure was due to reasonable cause and not to willful neglect, and

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

''(C) OVERALL LIMITATION FOR UNINTENTIONAL FAILURES.—In the case of failures

which are due to reasonable cause and not to willful neglect, the tax imposed by subsection (a) for failures during the taxable year of the employer shall not exceed the amount equal to the lesser of—

''(i) 10 percent of the aggregate amount paid or incurred by the employer (or predecessor employer) during the preceding taxable year for employment-based health plans, or

''(ii) $500,000.

''(D) COORDINATION WITH OTHER ENFORCEMENT PROVISIONS.—The tax imposed under paragraph (1) with respect to any failure shall be reduced (but not below zero) by the amount of any civil penalty collected under section 502(c)(11) of the Employee Retirement Income Security Act of 1974 or section 2793(g) of the Public Health Service Act with respect to such failure.

''(c) HEALTH COVERAGE PARTICIPATION REQUIREMENTS.—For purposes of this section, the term 'health coverage participation requirements' means the requirements of part I of subtitle B of title III of the America's

Affordable Health Choices Act of 2009 (as in effect on the date of the enactment of this section).''.

(b) CLERICAL AMENDMENT.—The table of sections for chapter 43 of such Code is amended by adding at the end the following new item:

''Sec. 4980H. Election to satisfy health coverage participation requirements.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to periods beginning after December 31, 2012.

SEC. 412. RESPONSIBILITIES OF NONELECTING EMPLOYERS.

(a) IN GENERAL.—Section 3111 of the Internal Revenue Code of 1986 is amended by redesignating subsection (c) as subsection (d) and by inserting after subsection (b) the following new subsection:

''(c) EMPLOYERS ELECTING TO NOT PROVIDE HEALTH BENEFITS.—

''(1) IN GENERAL.—In addition to other taxes, there is hereby imposed on every nonelecting employer an excise tax, with respect to having individuals in his employ, equal to 8 percent of the wages (as defined in section 3121(a)) paid by him with respect to employment (as defined in section 3121(b)).

''(2) SPECIAL RULES FOR SMALL EMPLOYERS.—

"(A) IN GENERAL.—In the case of any employer who is small employer for any calendar year, paragraph (1) shall be applied by substituting the applicable percentage determined in accordance with the following table for '8 percent':

"If the annual payroll of such employer for the preceding calendar year:	The applicable percentage is:
Does not exceed $250,000	0 percent
Exceeds $250,000, but does not exceed $300,000	2 percent
Exceeds $300,000, but does not exceed $350,000	4 percent
Exceeds $350,000, but does not exceed $400,000	6 percent

"(B) SMALL EMPLOYER.—For purposes of this paragraph, the term 'small employer' means any employer for any calendar year if the annual payroll of such employer for the preceding calendar year does not exceed $400,000.

"(C) ANNUAL PAYROLL.—For purposes of this paragraph, the term 'annual payroll' means, with respect to any employer for any calendar year, the aggregate wages (as defined in section 3121(a)) paid by him with respect to employment (as defined in section 3121(b)) during such calendar year.

"(3) NONELECTING EMPLOYER.—For purposes of paragraph (1), the term 'nonelecting employer' means any employer for any period with respect to

which such employer does not have an election under section 4980H(a) in effect.

''(4) SPECIAL RULE FOR SEPARATE ELECTIONS.—In the case of an employer who makes a separate election described in section 4980H(a)(4) for any period, paragraph (1) shall be applied for such period by taking into account only the wages paid to employees who are not subject to such election.

''(5) AGGREGATION; PREDECESSORS.—For purposes of this subsection—

''(A) all persons treated as a single employer under subsection (b), (c), (m), or (o) of section 414 shall be treated as 1 employer, and

''(B) any reference to any person shall be treated as including a reference to any predecessor of such person.''.

(b) DEFINITIONS.—Section 3121 of such Code is amended by adding at the end the following new subsection:

''(aa) SPECIAL RULES FOR TAX ON EMPLOYERS ELECTING NOT TO PROVIDE HEALTH BENEFITS.—For purposes of section 3111(c)—

''(1) Paragraphs (1), (5), and (19) of subsection (b) shall not apply.

''(2) Paragraph (7) of subsection (b) shall apply by treating all services as not covered by the retirement systems referred to in subparagraphs (C) and (F) thereof.

''(3) Subsection (e) shall not apply and the term 'State' shall include the District of Columbia.''.

(c) CONFORMING AMENDMENT.—Subsection (d) of section 3111 of such Code, as redesignated by this section, is amended by striking ''this section'' and inserting ''subsections (a) and (b)''.

(d) APPLICATION TO RAILROADS.—

(1) IN GENERAL.—Section 3221 of such Code is amended by redesignating subsection (c) as subsection (d) and by inserting after subsection (b) the following new subsection:

''(c) EMPLOYERS ELECTING TO NOT PROVIDE HEALTH BENEFITS.—

''(1) IN GENERAL.—In addition to other taxes, there is hereby imposed on every nonelecting employer an excise tax, with respect to having individuals in his employ, equal to 8 percent of the compensation paid during any calendar year by such employer for services rendered to such employer.

''(2) EXCEPTION FOR SMALL EMPLOYERS.—Rules similar to the rules of section 3111(c)(2) shall apply for purposes of this subsection.

''(3) NONELECTING EMPLOYER.—For purposes of paragraph (1), the term 'nonelecting employer' means any employer for any period with respect to which such employer does not have an election under section 4980H(a) in effect.

''(4) SPECIAL RULE FOR SEPARATE ELECTIONS.—In the case of an employer who makes a separate election described in section 4980H(a)(4) for any period, subsection (a) shall be applied for such period by taking into account only the wages paid to employees who are not subject to such election.''.

(2) DEFINITIONS.—Subsection (e) of section 3231 of such Code is amended by adding at the end the following new paragraph:

''(13) SPECIAL RULES FOR TAX ON EMPLOYERS ELECTING NOT TO PROVIDE HEALTH BENEFITS.—For purposes of section 3221(c)—

''(A) Paragraph (1) shall be applied without regard to the third sentence thereof.

''(B) Paragraph (2) shall not apply.''.

(3) CONFORMING AMENDMENT.—Subsection (d) of section 3221 of such Code, as redesignated by this section, is amended by striking ''subsections (a) and (b), see section 3231(e)(2)'' and inserting ''this section, see paragraphs (2) and (13)(B) of section 3231(e)''.

(e) EFFECTIVE DATE.—The amendments made by this section shall apply to periods beginning after December 31, 2012.

Subtitle B—Credit for Small Business Employee Health Coverage Expenses

SEC. 421. CREDIT FOR SMALL BUSINESS EMPLOYEE HEALTH COVERAGE EXPENSES.

(a) IN GENERAL.—Subpart D of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 (relating to business-related credits) is amended by adding at the end the following new section:

''SEC. 45R. SMALL BUSINESS EMPLOYEE HEALTH COVERAGE CREDIT.

''(a) IN GENERAL.—For purposes of section 38, in the case of a qualified small employer, the small business employee health coverage credit determined under this section for the taxable year is an amount equal to the applica-

ble percentage of the qualified employee health coverage expenses of such employer for such taxable year.

''(b) APPLICABLE PERCENTAGE.—

''(1) IN GENERAL.—For purposes of this section, the applicable percentage is 50 percent.

''(2) PHASEOUT BASED ON AVERAGE COMPENSATION OF EMPLOYEES.—In the case of an employer whose average annual employee compensation for the taxable year exceeds $20,000, the percentage specified in paragraph (1) shall be reduced by a number of percentage points which bears the same ratio to 50 as such excess bears to $20,000.

''(c) LIMITATIONS.—

''(1) PHASEOUT BASED ON EMPLOYER SIZE.—In the case of an employer who employs more than 10 qualified employees during the taxable year, the credit determined under subsection (a) shall be reduced by an amount which bears the same ratio to the amount of such credit (determined without regard to this paragraph and after the application of the other provisions of this section) as—

''(A) the excess of—

''(i) the number of qualified employees employed by the employer during the taxable year, over

''(ii) 10, bears to

''(B) 15.

''(2) CREDIT NOT ALLOWED WITH RESPECT TO CERTAIN HIGHLY COMPENSATED EMPLOYEES.—No credit shall be allowed under subsection (a) with respect to qualified employee health coverage expenses paid or incurred with respect to any employee for any taxable year if the aggregate compensation paid by the employer to such employee during such taxable year exceeds $80,000.

''(d) QUALIFIED EMPLOYEE HEALTH COVERAGE EXPENSES.—For purposes of this section—

''(1) IN GENERAL.—The term 'qualified employee health coverage expenses' means, with respect to any employer for any taxable year, the aggregate amount paid or incurred by such employer during such taxable year for coverage of any qualified employee of the employer (including any family coverage which covers such employee) under qualified health coverage.

''(2) QUALIFIED HEALTH COVERAGE.—The term 'qualified health coverage' means acceptable coverage (as defined in section 59B(d)) which—

''(A) is provided pursuant to an election under section 4980H(a), and

"(B) satisfies the requirements referred to in section 4980H(c).

"(e) OTHER DEFINITIONS.—For purposes of this section—

"(1) QUALIFIED SMALL EMPLOYER.—For purposes of this section, the term 'qualified small employer' means any employer for any taxable year if—

"(A) the number of qualified employees employed by such employer during the taxable year does not exceed 25, and

"(B) the average annual employee compensation of such employer for such taxable year does not exceed the sum of the dollar amounts in effect under subsection (b)(2).

"(2) QUALIFIED EMPLOYEE.—The term 'qualified employee' means any employee of an employer for any taxable year of the employer if such employee received at least $5,000 of compensation from such employer during such taxable year.

"(3) AVERAGE ANNUAL EMPLOYEE COMPENSATION.—The term 'average annual employee compensation' means, with respect to any employer for any taxable year, the average amount of compensa-

tion paid by such employer to qualified employees of such employer during such taxable year.

''(4) COMPENSATION.—The term 'compensation' has the meaning given such term in section 408(p)(6)(A).

''(5) FAMILY COVERAGE.—The term 'family coverage' means any coverage other than self-only coverage.

''(f) SPECIAL RULES.—For purposes of this section—

''(1) SPECIAL RULE FOR PARTNERSHIPS AND SELF-EMPLOYED.—In the case of a partnership (or a trade or business carried on by an individual) which has one or more qualified employees (determined without regard to this paragraph) with respect to whom the election under 4980H(a) applies, each partner (or, in the case of a trade or business carried on by an individual, such individual) shall be treated as an employee.

''(2) AGGREGATION RULE.—All persons treated as a single employer under subsection (b), (c), (m), or (o) of section 414 shall be treated as 1 employer.

''(3) DENIAL OF DOUBLE BENEFIT.—Any deduction otherwise allowable with respect to amounts paid or incurred for health insurance coverage to

which subsection (a) applies shall be reduced by the amount of the credit determined under this section.

''(4) INFLATION ADJUSTMENT.—In the case of any taxable year beginning after 2013, each of the dollar amounts in subsections (b)(2), (c)(2), and (e)(2) shall be increased by an amount equal to—

''(A) such dollar amount, multiplied by

''(B) the cost of living adjustment determined under section 1(f)(3) for the calendar year in which the taxable year begins determined by substituting 'calendar year 2012' for 'calendar year 1992' in subparagraph (B) thereof.

If any increase determined under this paragraph is not a multiple of $50, such increase shall be rounded to the next lowest multiple of $50.''.

(b) CREDIT TO BE PART OF GENERAL BUSINESS CREDIT.—Subsection (b) of section 38 of such Code (relating to general business credit) is amended by striking ''plus'' at the end of paragraph (34), by striking the period at the end of paragraph (35) and inserting '', plus'' , and by adding at the end the following new paragraph:

''(36) in the case of a qualified small employer (as defined in section 45R(e)), the small business

employee health coverage credit determined under section 45R(a).''.

(c) CLERICAL AMENDMENT.—The table of sections for subpart D of part IV of subchapter A of chapter 1 of such Code is amended by inserting after the item relating to section 45Q the following new item:

''Sec. 45R. Small business employee health coverage credit.''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2012.

Subtitle C—Disclosures to Carry Out Health Insurance Exchange Subsidies

SEC. 431. DISCLOSURES TO CARRY OUT HEALTH INSURANCE EXCHANGE SUBSIDIES.

(a) IN GENERAL.—Subsection (l) of section 6103 of the Internal Revenue Code of 1986 is amended by adding at the end the following new paragraph:

''(21) DISCLOSURE OF RETURN INFORMATION TO CARRY OUT HEALTH INSURANCE EXCHANGE SUBSIDIES.—

''(A) IN GENERAL.—The Secretary, upon written request from the Health Choices Commissioner or the head of a State-based health insurance exchange approved for operation under section 208 of the America's Affordable

Health Choices Act of 2009, shall disclose to officers and employees of the Health Choices Administration or such State-based health insurance exchange, as the case may be, return information of any taxpayer whose income is relevant in determining any affordability credit described in subtitle C of title II of the America's Affordable Health Choices Act of 2009. Such return information shall be limited to—

''(i) taxpayer identity information with respect to such taxpayer,

''(ii) the filing status of such taxpayer,

''(iii) the modified adjusted gross income of such taxpayer (as defined in section 59B(e)(5)),

''(iv) the number of dependents of the taxpayer,

''(v) such other information as is prescribed by the Secretary by regulation as might indicate whether the taxpayer is eligible for such affordability credits (and the amount thereof), and

''(vi) the taxable year with respect to which the preceding information relates or,

if applicable, the fact that such information is not available.

''(B) RESTRICTION ON USE OF DISCLOSED INFORMATION.—Return information disclosed under subparagraph (A) may be used by officers and employees of the Health Choices Administration or such State-based health insurance exchange, as the case may be, only for the purposes of, and to the extent necessary in, establishing and verifying the appropriate amount of any affordability credit described in subtitle C of title II of the America's Affordable Health Choices Act of 2009 and providing for the repayment of any such credit which was in excess of such appropriate amount.''.

(b) PROCEDURES AND RECORDKEEPING RELATED TO DISCLOSURES.—Paragraph (4) of section 6103(p) of such Code is amended—

(1) by inserting '', or any entity described in subsection (l)(21),'' after ''or (20)'' in the matter preceding subparagraph (A),

(2) by inserting ''or any entity described in subsection (l)(21),'' after ''or (o)(1)(A)'' in subparagraph (F)(ii), and

(3) by inserting ''or any entity described in subsection (l)(21),'' after ''or (20)'' both places it appears in the matter after subparagraph (F).

(c) UNAUTHORIZED DISCLOSURE OR INSPECTION.—Paragraph (2) of section 7213(a) of such Code is amended by striking ''or (20)'' and inserting ''(20), or (21)''.

Subtitle D—Other Revenue Provisions

PART 1—GENERAL PROVISIONS

SEC. 441. SURCHARGE ON HIGH INCOME INDIVIDUALS.

(a) IN GENERAL.—Part VIII of subchapter A of chapter 1 of the Internal Revenue Code of 1986, as added by this title, is amended by adding at the end the following new subpart:

''**Subpart B—Surcharge on High Income Individuals**

''Sec. 59C. Surcharge on high income individuals.

''**SEC. 59C. SURCHARGE ON HIGH INCOME INDIVIDUALS.**

''(a) GENERAL RULE.—In the case of a taxpayer other than a corporation, there is hereby imposed (in addition to any other tax imposed by this subtitle) a tax equal to—

''(1) 1 percent of so much of the modified adjusted gross income of the taxpayer as exceeds $350,000 but does not exceed $500,000,

''(2) 1.5 percent of so much of the modified adjusted gross income of the taxpayer as exceeds $500,000 but does not exceed $1,000,000, and

''(3) 5.4 percent of so much of the modified adjusted gross income of the taxpayer as exceeds $1,000,000.

''(b) TAXPAYERS NOT MAKING A JOINT RETURN.—In the case of any taxpayer other than a taxpayer making a joint return under section 6013 or a surviving spouse (as defined in section 2(a)), subsection (a) shall be applied by substituting for each of the dollar amounts therein (after any increase determined under subsection (e)) a dollar amount equal to—

''(1) 50 percent of the dollar amount so in effect in the case of a married individual filing a separate return, and

''(2) 80 percent of the dollar amount so in effect in any other case.

''(c) ADJUSTMENTS BASED ON FEDERAL HEALTH REFORM SAVINGS.—

''(1) IN GENERAL.—Except as provided in paragraph (2), in the case of any taxable year beginning after December 31, 2012, subsection (a) shall be applied—

"(A) by substituting '2 percent' for '1 percent', and

"(B) by substituting '3 percent' for '1.5 percent'.

"(2) ADJUSTMENTS BASED ON EXCESS FEDERAL HEALTH REFORM SAVINGS.—

"(A) EXCEPTION IF FEDERAL HEALTH REFORM SAVINGS SIGNIFICANTLY EXCEEDS BASE AMOUNT.—If the excess Federal health reform savings is more than $150,000,000,000 but not more than $175,000,000,000, paragraph (1) shall not apply.

"(B) FURTHER ADJUSTMENT FOR ADDITIONAL FEDERAL HEALTH REFORM SAVINGS.—If the excess Federal health reform savings is more than $175,000,000,000, paragraphs (1) and (2) of subsection (a) (and paragraph (1) of this subsection) shall not apply to any taxable year beginning after December 31, 2012.

"(C) EXCESS FEDERAL HEALTH REFORM SAVINGS.—For purposes of this subsection, the term 'excess Federal health reform savings' means the excess of—

"(i) the Federal health reform savings, over

"(ii) $525,000,000,000.

"(D) FEDERAL HEALTH REFORM SAVINGS.—The term 'Federal health reform savings' means the sum of the amounts described in subparagraphs (A) and (B) of paragraph (3).

"(3) DETERMINATION OF FEDERAL HEALTH REFORM SAVINGS.—Not later than December 1, 2012, the Director of the Office of Management and Budget shall—

"(A) determine, on the basis of the study conducted under paragraph (4), the aggregate reductions in Federal expenditures which have been achieved as a result of the provisions of, and amendments made by, division B of the America's Affordable Health Choices Act of 2009 during the period beginning on October 1, 2009, and ending with the latest date with respect to which the Director has sufficient data to make such determination, and

"(B) estimate, on the basis of such study and the determination under subparagraph (A), the aggregate reductions in Federal expenditures which will be achieved as a result of such provisions and amendments during so much of the period beginning with fiscal year 2010 and

ending with fiscal year 2019 as is not taken into account under subparagraph (A).

''(4) STUDY OF FEDERAL HEALTH REFORM SAVINGS.—The Director of the Office of Management and Budget shall conduct a study of the reductions in Federal expenditures during fiscal years 2010 through 2019 which are attributable to the provisions of, and amendments made by, division B of the America's Affordable Health Choices Act of 2009. The Director shall complete such study not later than December 1, 2012.

''(5) REDUCTIONS IN FEDERAL EXPENDITURES DETERMINED WITHOUT REGARD TO PROGRAM INVESTMENTS.—For purposes of paragraphs (3) and (4), reductions in Federal expenditures shall be determined without regard to section 1121 of the America's Affordable Health Choices Act of 2009 and other program investments under division B thereof.

''(d) MODIFIED ADJUSTED GROSS INCOME.—For purposes of this section, the term 'modified adjusted gross income' means adjusted gross income reduced by any deduction allowed for investment interest (as defined in section 163(d)). In the case of an estate or trust, adjusted

gross income shall be determined as provided in section 67(e).

''(e) INFLATION ADJUSTMENTS.—

''(1) IN GENERAL.—In the case of taxable years beginning after 2011, the dollar amounts in subsection (a) shall be increased by an amount equal to—

''(A) such dollar amount, multiplied by

''(B) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year in which the taxable year begins, by substituting 'calendar year 2010' for 'calendar year 1992' in subparagraph (B) thereof.

''(2) ROUNDING.—If any amount as adjusted under paragraph (1) is not a multiple of $5,000, such amount shall be rounded to the next lowest multiple of $5,000.

''(f) SPECIAL RULES.—

''(1) NONRESIDENT ALIEN.—In the case of a nonresident alien individual, only amounts taken into account in connection with the tax imposed under section 871(b) shall be taken into account under this section.

''(2) CITIZENS AND RESIDENTS LIVING ABROAD.—The dollar amounts in effect under sub-

section (a) (after the application of subsections (b) and (e)) shall be decreased by the excess of—

"(A) the amounts excluded from the taxpayer's gross income under section 911, over

"(B) the amounts of any deductions or exclusions disallowed under section 911(d)(6) with respect to the amounts described in subparagraph (A).

"(3) CHARITABLE TRUSTS.—Subsection (a) shall not apply to a trust all the unexpired interests in which are devoted to one or more of the purposes described in section 170(c)(2)(B).

"(4) NOT TREATED AS TAX IMPOSED BY THIS CHAPTER FOR CERTAIN PURPOSES.—The tax imposed under this section shall not be treated as tax imposed by this chapter for purposes of determining the amount of any credit under this chapter or for purposes of section 55.".

(b) CLERICAL AMENDMENT.—The table of subparts for part VIII of subchapter A of chapter 1 of such Code, as added by this title, is amended by inserting after the item relating to subpart A the following new item:

"SUBPART B. SURCHARGE ON HIGH INCOME INDIVIDUALS.".

(c) SECTION 15 NOT TO APPLY.—The amendment made by subsection (a) shall not be treated as a change

in a rate of tax for purposes of section 15 of the Internal Revenue Code of 1986.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2010.

SEC. 442. DELAY IN APPLICATION OF WORLDWIDE ALLOCATION OF INTEREST.

(a) IN GENERAL.—Paragraphs (5)(D) and (6) of section 864(f) of the Internal Revenue Code of 1986 are each amended by striking ''December 31, 2010'' and inserting ''December 31, 2019''.

(b) TRANSITION.—Subsection (f) of section 864 of such Code is amended by striking paragraph (7).

PART 2—PREVENTION OF TAX AVOIDANCE

SEC. 451. LIMITATION ON TREATY BENEFITS FOR CERTAIN DEDUCTIBLE PAYMENTS.

(a) IN GENERAL.—Section 894 of the Internal Revenue Code of 1986 (relating to income affected by treaty) is amended by adding at the end the following new subsection:

''(d) LIMITATION ON TREATY BENEFITS FOR CERTAIN DEDUCTIBLE PAYMENTS.—

''(1) IN GENERAL.—In the case of any deductible related-party payment, any withholding tax imposed under chapter 3 (and any tax imposed under

subpart A or B of this part) with respect to such payment may not be reduced under any treaty of the United States unless any such withholding tax would be reduced under a treaty of the United States if such payment were made directly to the foreign parent corporation.

''(2) DEDUCTIBLE RELATED-PARTY PAYMENT.—For purposes of this subsection, the term 'deductible related-party payment' means any payment made, directly or indirectly, by any person to any other person if the payment is allowable as a deduction under this chapter and both persons are members of the same foreign controlled group of entities.

''(3) FOREIGN CONTROLLED GROUP OF ENTITIES.—For purposes of this subsection—

''(A) IN GENERAL.—The term 'foreign controlled group of entities' means a controlled group of entities the common parent of which is a foreign corporation.

''(B) CONTROLLED GROUP OF ENTITIES.—The term 'controlled group of entities' means a controlled group of corporations as defined in section 1563(a)(1), except that—

"(i) 'more than 50 percent' shall be substituted for 'at least 80 percent' each place it appears therein, and

"(ii) the determination shall be made without regard to subsections (a)(4) and (b)(2) of section 1563.

A partnership or any other entity (other than a corporation) shall be treated as a member of a controlled group of entities if such entity is controlled (within the meaning of section 954(d)(3)) by members of such group (including any entity treated as a member of such group by reason of this sentence).

"(4) FOREIGN PARENT CORPORATION.—For purposes of this subsection, the term 'foreign parent corporation' means, with respect to any deductible related-party payment, the common parent of the foreign controlled group of entities referred to in paragraph (3)(A).

"(5) REGULATIONS.—The Secretary may prescribe such regulations or other guidance as are necessary or appropriate to carry out the purposes of this subsection, including regulations or other guidance which provide for—

''(A) the treatment of two or more persons as members of a foreign controlled group of entities if such persons would be the common parent of such group if treated as one corporation, and

''(B) the treatment of any member of a foreign controlled group of entities as the common parent of such group if such treatment is appropriate taking into account the economic relationships among such entities.''.

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to payments made after the date of the enactment of this Act.

SEC. 452. CODIFICATION OF ECONOMIC SUBSTANCE DOCTRINE.

(a) IN GENERAL.—Section 7701 of the Internal Revenue Code of 1986 is amended by redesignating subsection (o) as subsection (p) and by inserting after subsection (n) the following new subsection:

''(o) CLARIFICATION OF ECONOMIC SUBSTANCE DOCTRINE.—

''(1) APPLICATION OF DOCTRINE.—In the case of any transaction to which the economic substance doctrine is relevant, such transaction shall be treated as having economic substance only if—

''(A) the transaction changes in a meaningful way (apart from Federal income tax effects) the taxpayer's economic position, and

''(B) the taxpayer has a substantial purpose (apart from Federal income tax effects) for entering into such transaction.

''(2) SPECIAL RULE WHERE TAXPAYER RELIES ON PROFIT POTENTIAL.—

''(A) IN GENERAL.—The potential for profit of a transaction shall be taken into account in determining whether the requirements of subparagraphs (A) and (B) of paragraph (1) are met with respect to the transaction only if the present value of the reasonably expected pre-tax profit from the transaction is substantial in relation to the present value of the expected net tax benefits that would be allowed if the transaction were respected.

''(B) TREATMENT OF FEES AND FOREIGN TAXES.—Fees and other transaction expenses and foreign taxes shall be taken into account as expenses in determining pre-tax profit under subparagraph (A).

''(3) STATE AND LOCAL TAX BENEFITS.—For purposes of paragraph (1), any State or local income

tax effect which is related to a Federal income tax effect shall be treated in the same manner as a Federal income tax effect.

''(4) FINANCIAL ACCOUNTING BENEFITS.—For purposes of paragraph (1)(B), achieving a financial accounting benefit shall not be taken into account as a purpose for entering into a transaction if the origin of such financial accounting benefit is a reduction of Federal income tax.

''(5) DEFINITIONS AND SPECIAL RULES.—For purposes of this subsection—

''(A) ECONOMIC SUBSTANCE DOCTRINE.—The term 'economic substance doctrine' means the common law doctrine under which tax benefits under subtitle A with respect to a transaction are not allowable if the transaction does not have economic substance or lacks a business purpose.

''(B) EXCEPTION FOR PERSONAL TRANSACTIONS OF INDIVIDUALS.—In the case of an individual, paragraph (1) shall apply only to transactions entered into in connection with a trade or business or an activity engaged in for the production of income.

''(C) OTHER COMMON LAW DOCTRINES NOT AFFECTED.—Except as specifically provided in this subsection, the provisions of this subsection shall not be construed as altering or supplanting any other rule of law, and the requirements of this subsection shall be construed as being in addition to any such other rule of law.

''(D) DETERMINATION OF APPLICATION OF DOCTRINE NOT AFFECTED.—The determination of whether the economic substance doctrine is relevant to a transaction (or series of transactions) shall be made in the same manner as if this subsection had never been enacted.

''(6) REGULATIONS.—The Secretary shall prescribe such regulations as may be necessary or appropriate to carry out the purposes of this subsection.''.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to transactions entered into after the date of the enactment of this Act.

SEC. 453. PENALTIES FOR UNDERPAYMENTS.

(a) PENALTY FOR UNDERPAYMENTS ATTRIBUTABLE TO TRANSACTIONS LACKING ECONOMIC SUBSTANCE.—

(1) IN GENERAL.—Subsection (b) of section 6662 of the Internal Revenue Code of 1986 is amended by inserting after paragraph (5) the following new paragraph:

''(6) Any disallowance of claimed tax benefits by reason of a transaction lacking economic substance (within the meaning of section 7701(o)) or failing to meet the requirements of any similar rule of law.''.

(2) INCREASED PENALTY FOR NONDISCLOSED TRANSACTIONS.—Section 6662 of such Code is amended by adding at the end the following new subsection:

''(i) INCREASE IN PENALTY IN CASE OF NONDISCLOSED NONECONOMIC SUBSTANCE TRANSACTIONS.—

''(1) IN GENERAL.—In the case of any portion of an underpayment which is attributable to one or more nondisclosed noneconomic substance transactions, subsection (a) shall be applied with respect to such portion by substituting '40 percent' for '20 percent'.

''(2) NONDISCLOSED NONECONOMIC SUBSTANCE TRANSACTIONS.—For purposes of this subsection, the term 'nondisclosed noneconomic substance transaction' means any portion of a trans-

action described in subsection (b)(6) with respect to which the relevant facts affecting the tax treatment are not adequately disclosed in the return nor in a statement attached to the return.

''(3) SPECIAL RULE FOR AMENDED RETURNS.—Except as provided in regulations, in no event shall any amendment or supplement to a return of tax be taken into account for purposes of this subsection if the amendment or supplement is filed after the earlier of the date the taxpayer is first contacted by the Secretary regarding the examination of the return or such other date as is specified by the Secretary.''.

(3) CONFORMING AMENDMENT.—Subparagraph (B) of section 6662A(e)(2) of such Code is amended—

(A) by striking ''section 6662(h)'' and inserting ''subsections (h) or (i) of section 6662'', and

(B) by striking ''GROSS VALUATION MISSTATEMENT PENALTY'' in the heading and inserting ''CERTAIN INCREASED UNDERPAYMENT PENALTIES''.

(b) REASONABLE CAUSE EXCEPTION NOT APPLICABLE TO NONECONOMIC SUBSTANCE TRANSACTIONS, TAX

SHELTERS, AND CERTAIN LARGE OR PUBLICLY TRADED PERSONS.—Subsection (c) of section 6664 of such Code is amended—

(1) by redesignating paragraphs (2) and (3) as paragraphs (3) and (4), respectively,

(2) by striking ''paragraph (2)'' in paragraph (4), as so redesignated, and inserting ''paragraph (3)'', and

(3) by inserting after paragraph (1) the following new paragraph:

''(2) EXCEPTION.—Paragraph (1) shall not apply to—

''(A) to any portion of an underpayment which is attributable to one or more tax shelters (as defined in section 6662(d)(2)(C)) or transactions described in section 6662(b)(6), and

''(B) to any taxpayer if such taxpayer is a specified person (as defined in section 6662(d)(2)(D)(ii)).''.

(c) APPLICATION OF PENALTY FOR ERRONEOUS CLAIM FOR REFUND OR CREDIT TO NONECONOMIC SUBSTANCE TRANSACTIONS.—Section 6676 of such Code is amended by redesignating subsection (c) as subsection (d) and inserting after subsection (b) the following new subsection:

''(c) NONECONOMIC SUBSTANCE TRANSACTIONS TREATED AS LACKING REASONABLE BASIS.—For purposes of this section, any excessive amount which is attributable to any transaction described in section 6662(b)(6) shall not be treated as having a reasonable basis.''.

(d) SPECIAL UNDERSTATEMENT REDUCTION RULE FOR CERTAIN LARGE OR PUBLICLY TRADED PERSONS.—

(1) IN GENERAL.—Paragraph (2) of section 6662(d) of such Code is amended by adding at the end the following new subparagraph:

''(D) SPECIAL REDUCTION RULE FOR CERTAIN LARGE OR PUBLICLY TRADED PERSONS.—

''(i) IN GENERAL.—In the case of any specified person—

''(I) subparagraph (B) shall not apply, and

''(II) the amount of the understatement under subparagraph (A) shall be reduced by that portion of the understatement which is attributable to any item with respect to which the taxpayer has a reasonable belief that the tax treatment of such item by the taxpayer is more likely than not the proper tax treatment of such item.

''(ii) SPECIFIED PERSON.—For purposes of this subparagraph, the term 'specified person' means—

''(I) any person required to file periodic or other reports under section 13 of the Securities Exchange Act of 1934, and

''(II) any corporation with gross receipts in excess of $100,000,000 for the taxable year involved.

All persons treated as a single employer under section 52(a) shall be treated as one person for purposes of subclause (II).''.

(2) CONFORMING AMENDMENT.—Subparagraph (C) of section 6662(d)(2) of such Code is amended by striking ''Subparagraph (B)'' and inserting ''Subparagraphs (B) and (D)(i)(II)''.

(e) EFFECTIVE DATE.—The amendments made by this section shall apply to transactions entered into after the date of the enactment of this Act.

DIVISION B—MEDICARE AND MEDICAID IMPROVEMENTS

SEC. 1001. TABLE OF CONTENTS OF DIVISION.

The table of contents for this division is as follows:

DIVISION B—MEDICARE AND MEDICAID IMPROVEMENTS

Sec. 1001. Table of contents of division.

TITLE I—IMPROVING HEALTH CARE VALUE

Subtitle A—Provisions Related to Medicare Part A

PART 1—MARKET BASKET UPDATES

Sec. 1101. Skilled nursing facility payment update.
Sec. 1102. Inpatient rehabilitation facility payment update.
Sec. 1103. Incorporating productivity improvements into market basket updates that do not already incorporate such improvements.

PART 2—OTHER MEDICARE PART A PROVISIONS

Sec. 1111. Payments to skilled nursing facilities.
Sec. 1112. Medicare DSH report and payment adjustments in response to coverage expansion.

Subtitle B—Provisions Related to Part B

PART 1—PHYSICIANS' SERVICES

Sec. 1121. Sustainable growth rate reform.
Sec. 1122. Misvalued codes under the physician fee schedule.
Sec. 1123. Payments for efficient areas.
Sec. 1124. Modifications to the Physician Quality Reporting Initiative (PQRI).
Sec. 1125. Adjustment to Medicare payment localities.

PART 2—MARKET BASKET UPDATES

Sec. 1131. Incorporating productivity improvements into market basket updates that do not already incorporate such improvements.

PART 3—OTHER PROVISIONS

Sec. 1141. Rental and purchase of power-driven wheelchairs.
Sec. 1142. Extension of payment rule for brachytherapy.
Sec. 1143. Home infusion therapy report to congress.
Sec. 1144. Require ambulatory surgical centers (ASCs) to submit cost data and other data.
Sec. 1145. Treatment of certain cancer hospitals.
Sec. 1146. Medicare Improvement Fund.
Sec. 1147. Payment for imaging services.
Sec. 1148. Durable medical equipment program improvements.
Sec. 1149. MedPAC study and report on bone mass measurement.

Subtitle C—Provisions Related to Medicare Parts A and B

Sec. 1151. Reducing potentially preventable hospital readmissions.
Sec. 1152. Post acute care services payment reform plan and bundling pilot program.
Sec. 1153. Home health payment update for 2010.
Sec. 1154. Payment adjustments for home health care.
Sec. 1155. Incorporating productivity improvements into market basket update for home health services.
Sec. 1156. Limitation on Medicare exceptions to the prohibition on certain physician referrals made to hospitals.
Sec. 1157. Institute of Medicine study of geographic adjustment factors under Medicare.

Sec. 1158. Revision of Medicare payment systems to address geographic inequities.

Subtitle D—Medicare Advantage Reforms

Part 1—Payment and Administration

Sec. 1161. Phase-in of payment based on fee-for-service costs.
Sec. 1162. Quality bonus payments.
Sec. 1163. Extension of Secretarial coding intensity adjustment authority.
Sec. 1164. Simplification of annual beneficiary election periods.
Sec. 1165. Extension of reasonable cost contracts.
Sec. 1166. Limitation of waiver authority for employer group plans.
Sec. 1167. Improving risk adjustment for payments.
Sec. 1168. Elimination of MA Regional Plan Stabilization Fund.

Part 2—Beneficiary Protections and Anti-Fraud

Sec. 1171. Limitation on cost-sharing for individual health services.
Sec. 1172. Continuous open enrollment for enrollees in plans with enrollment suspension.
Sec. 1173. Information for beneficiaries on MA plan administrative costs.
Sec. 1174. Strengthening audit authority.
Sec. 1175. Authority to deny plan bids.

Part 3—Treatment of Special Needs Plans

Sec. 1176. Limitation on enrollment outside open enrollment period of individuals into chronic care specialized MA plans for special needs individuals.
Sec. 1177. Extension of authority of special needs plans to restrict enrollment.

Subtitle E—Improvements to Medicare Part D

Sec. 1181. Elimination of coverage gap.
Sec. 1182. Discounts for certain part D drugs in original coverage gap.
Sec. 1183. Repeal of provision relating to submission of claims by pharmacies located in or contracting with long-term care facilities.
Sec. 1184. Including costs incurred by AIDS drug assistance programs and Indian Health Service in providing prescription drugs toward the annual out-of-pocket threshold under part D.
Sec. 1185. Permitting mid-year changes in enrollment for formulary changes that adversely impact an enrollee.

Subtitle F—Medicare Rural Access Protections

Sec. 1191. Telehealth expansion and enhancements.
Sec. 1192. Extension of outpatient hold harmless provision.
Sec. 1193. Extension of section 508 hospital reclassifications.
Sec. 1194. Extension of geographic floor for work.
Sec. 1195. Extension of payment for technical component of certain physician pathology services.
Sec. 1196. Extension of ambulance add-ons.

TITLE II—MEDICARE BENEFICIARY IMPROVEMENTS

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

Sec. 1201. Improving assets tests for Medicare Savings Program and low-income subsidy program.
Sec. 1202. Elimination of part D cost-sharing for certain non-institutionalized full-benefit dual eligible individuals.
Sec. 1203. Eliminating barriers to enrollment.
Sec. 1204. Enhanced oversight relating to reimbursements for retroactive low income subsidy enrollment.
Sec. 1205. Intelligent assignment in enrollment.
Sec. 1206. Special enrollment period and automatic enrollment process for certain subsidy eligible individuals.
Sec. 1207. Application of MA premiums prior to rebate in calculation of low income subsidy benchmark.

Subtitle B—Reducing Health Disparities

Sec. 1221. Ensuring effective communication in Medicare.
Sec. 1222. Demonstration to promote access for Medicare beneficiaries with limited English proficiency by providing reimbursement for culturally and linguistically appropriate services.
Sec. 1223. IOM report on impact of language access services.
Sec. 1224. Definitions.

Subtitle C—Miscellaneous Improvements

Sec. 1231. Extension of therapy caps exceptions process.
Sec. 1232. Extended months of coverage of immunosuppressive drugs for kidney transplant patients and other renal dialysis provisions.
Sec. 1233. Advance care planning consultation.
Sec. 1234. Part B special enrollment period and waiver of limited enrollment penalty for TRICARE beneficiaries.
Sec. 1235. Exception for use of more recent tax year in case of gains from sale of primary residence in computing part B income-related premium.
Sec. 1236. Demonstration program on use of patient decisions aids.

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

Sec. 1301. Accountable Care Organization pilot program.
Sec. 1302. Medical home pilot program.
Sec. 1303. Payment incentive for selected primary care services.
Sec. 1304. Increased reimbursement rate for certified nurse-midwives.
Sec. 1305. Coverage and waiver of cost-sharing for preventive services.
Sec. 1306. Waiver of deductible for colorectal cancer screening tests regardless of coding, subsequent diagnosis, or ancillary tissue removal.
Sec. 1307. Excluding clinical social worker services from coverage under the medicare skilled nursing facility prospective payment system and consolidated payment.
Sec. 1308. Coverage of marriage and family therapist services and mental health counselor services.
Sec. 1309. Extension of physician fee schedule mental health add-on.
Sec. 1310. Expanding access to vaccines.

TITLE IV—QUALITY

Subtitle A—Comparative Effectiveness Research

Sec. 1401. Comparative effectiveness research.

Subtitle B—Nursing Home Transparency

Part 1—Improving Transparency of Information on Skilled Nursing Facilities and Nursing Facilities

Sec. 1411. Required disclosure of ownership and additional disclosable parties information.
Sec. 1412. Accountability requirements.
Sec. 1413. Nursing home compare Medicare website.
Sec. 1414. Reporting of expenditures.
Sec. 1415. Standardized complaint form.
Sec. 1416. Ensuring staffing accountability.

Part 2—Targeting Enforcement

Sec. 1421. Civil money penalties.
Sec. 1422. National independent monitor pilot program.
Sec. 1423. Notification of facility closure.

Part 3—Improving Staff Training

Sec. 1431. Dementia and abuse prevention training.
Sec. 1432. Study and report on training required for certified nurse aides and supervisory staff.

Subtitle C—Quality Measurements

Sec. 1441. Establishment of national priorities for quality improvement.
Sec. 1442. Development of new quality measures; GAO evaluation of data collection process for quality measurement.
Sec. 1443. Multi-stakeholder pre-rulemaking input into selection of quality measures.
Sec. 1444. Application of quality measures.
Sec. 1445. Consensus-based entity funding.

Subtitle D—Physician Payments Sunshine Provision

Sec. 1451. Reports on financial relationships between manufacturers and distributors of covered drugs, devices, biologicals, or medical supplies under Medicare, Medicaid, or CHIP and physicians and other health care entities and between physicians and other health care entities.

Subtitle E—Public Reporting on Health Care-Associated Infections

Sec. 1461. Requirement for public reporting by hospitals and ambulatory surgical centers on health care-associated infections.

TITLE V—MEDICARE GRADUATE MEDICAL EDUCATION

Sec. 1501. Distribution of unused residency positions.
Sec. 1502. Increasing training in nonprovider settings.
Sec. 1503. Rules for counting resident time for didactic and scholarly activities and other activities.
Sec. 1504. Preservation of resident cap positions from closed hospitals.
Sec. 1505. Improving accountability for approved medical residency training.

TITLE VI—PROGRAM INTEGRITY

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

Sec. 1601. Increased funding and flexibility to fight fraud and abuse.

Subtitle B—Enhanced Penalties for Fraud and Abuse

Sec. 1611. Enhanced penalties for false statements on provider or supplier enrollment applications.
Sec. 1612. Enhanced penalties for submission of false statements material to a false claim.
Sec. 1613. Enhanced penalties for delaying inspections.
Sec. 1614. Enhanced hospice program safeguards.
Sec. 1615. Enhanced penalties for individuals excluded from program participation.
Sec. 1616. Enhanced penalties for provision of false information by Medicare Advantage and part D plans.
Sec. 1617. Enhanced penalties for Medicare Advantage and part D marketing violations.
Sec. 1618. Enhanced penalties for obstruction of program audits.
Sec. 1619. Exclusion of certain individuals and entities from participation in Medicare and State health care programs.

Subtitle C—Enhanced Program and Provider Protections

Sec. 1631. Enhanced CMS program protection authority.
Sec. 1632. Enhanced Medicare, Medicaid, and CHIP program disclosure requirements relating to previous affiliations.
Sec. 1633. Required inclusion of payment modifier for certain evaluation and management services.
Sec. 1634. Evaluations and reports required under Medicare Integrity Program.
Sec. 1635. Require providers and suppliers to adopt programs to reduce waste, fraud, and abuse.
Sec. 1636. Maximum period for submission of Medicare claims reduced to not more than 12 months.
Sec. 1637. Physicians who order durable medical equipment or home health services required to be Medicare enrolled physicians or eligible professionals.
Sec. 1638. Requirement for physicians to provide documentation on referrals to programs at high risk of waste and abuse.
Sec. 1639. Face to face encounter with patient required before physicians may certify eligibility for home health services or durable medical equipment under Medicare.
Sec. 1640. Extension of testimonial subpoena authority to program exclusion investigations.
Sec. 1641. Required repayments of Medicare and Medicaid overpayments.
Sec. 1642. Expanded application of hardship waivers for OIG exclusions to beneficiaries of any Federal health care program.
Sec. 1643. Access to certain information on renal dialysis facilities.
Sec. 1644. Billing agents, clearinghouses, or other alternate payees required to register under Medicare.
Sec. 1645. Conforming civil monetary penalties to False Claims Act amendments.

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

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Sec. 1901. Repeal of trigger provision.
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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.

(a) IN GENERAL.—Section 1888(e)(4)(E)(ii) of the Social Security Act (42 U.S.C. 1395yy(e)(4)(E)(ii)) is amended—

(1) in subclause (III), by striking ''and'' at the end;

(2) by redesignating subclause (IV) as subclause (VI); and

(3) by inserting after subclause (III) the following new subclauses:

''(IV) for each of fiscal years 2004 through 2009, the rate computed for the previous fiscal year increased by the skilled nursing facility market basket percentage change for the fiscal year involved;

''(V) for fiscal year 2010, the rate computed for the previous fiscal year; and''.

(b) DELAYED EFFECTIVE DATE.—Section 1888(e)(4)(E)(ii)(V) of the Social Security Act, as inserted by subsection (a)(3), shall not apply to payment for days before January 1, 2010.

SEC. 1102. INPATIENT REHABILITATION FACILITY PAYMENT UPDATE.

(a) IN GENERAL.—Section 1886(j)(3)(C) of the Social Security Act (42 U.S.C. 1395ww(j)(3)(C)) is amended by striking ''and 2009'' and inserting ''through 2010''.

(b) DELAYED EFFECTIVE DATE.—The amendment made by subsection (a) shall not apply to payment units occurring before January 1, 2010.

SEC. 1103. INCORPORATING PRODUCTIVITY IMPROVEMENTS INTO MARKET BASKET UPDATES THAT DO NOT ALREADY INCORPORATE SUCH IMPROVEMENTS.

(a) INPATIENT ACUTE HOSPITALS.—Section 1886(b)(3)(B) of the Social Security Act (42 U.S.C. 1395ww(b)(3)(B)) is amended—

(1) in clause (iii)—

(A) by striking ''(iii) For purposes of this subparagraph,'' and inserting ''(iii)(I) For purposes of this subparagraph, subject to the productivity adjustment described in subclause (II),''; and

(B) by adding at the end the following new subclause:

''(II) The productivity adjustment described in this subclause, with respect to an increase or change for a fiscal year or year or cost reporting period, or other annual period, is a productivity offset equal to the percentage change in the 10-year moving average of annual economy-wide private nonfarm business multi-factor productivity (as recently published before the promulgation of such increase for the year or period involved). Except as otherwise provided, any reference to the increase described in this clause shall be a reference to the percentage increase described in subclause (I) minus the percentage change under this subclause.'';

(2) in the first sentence of clause (viii)(I), by inserting ''(but not below zero)'' after ''shall be reduced''; and

(3) in the first sentence of clause (ix)(I)—

(A) by inserting ''(determined without regard to clause (iii)(II)'' after ''clause (i)'' the second time it appears; and

(B) by inserting ''(but not below zero)'' after ''reduced''.

(b) SKILLED NURSING FACILITIES.—Section 1888(e)(5)(B) of such Act (42 U.S.C. 1395yy(e)(5))(B)

is amended by inserting ''subject to the productivity adjustment described in section 1886(b)(3)(B)(iii)(II)'' after ''as calculated by the Secretary''.

(c) LONG TERM CARE HOSPITALS.—Section 1886(m) of the Social Security Act (42 U.S.C. 1395ww(m)) is amended by adding at the end the following new paragraph:

''(3) PRODUCTIVITY ADJUSTMENT.—In implementing the system described in paragraph (1) for discharges occurring during the rate year ending in 2010 or any subsequent rate year for a hospital, to the extent that an annual percentage increase factor applies to a base rate for such discharges for the hospital, such factor shall be subject to the productivity adjustment described in section 1886(b)(3)(B)(iii)(II).''.

(d) INPATIENT REHABILITATION FACILITIES.—The second sentence of section 1886(j)(3)(C) of the Social Security Act (42 U.S.C. 1395ww(j)(3)(C)) is amended by inserting ''(subject to the productivity adjustment described in section 1886(b)(3)(B)(iii)(II))'' after ''appropriate percentage increase''.

(e) PSYCHIATRIC HOSPITALS.—Section 1886 of the Social Security Act (42 U.S.C. 1395ww) is amended by adding at the end the following new subsection:

''(o) PROSPECTIVE PAYMENT FOR PSYCHIATRIC HOSPITALS.—

''(1) REFERENCE TO ESTABLISHMENT AND IMPLEMENTATION OF SYSTEM.—For provisions related to the establishment and implementation of a prospective payment system for payments under this title for inpatient hospital services furnished by psychiatric hospitals (as described in clause (i) of subsection (d)(1)(B) and psychiatric units (as described in the matter following clause (v) of such subsection), see section 124 of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999.

''(2) PRODUCTIVITY ADJUSTMENT.—In implementing the system described in paragraph (1) for discharges occurring during the rate year ending in 2011 or any subsequent rate year for a psychiatric hospital or unit described in such paragraph, to the extent that an annual percentage increase factor applies to a base rate for such discharges for the hospital or unit, respectively, such factor shall be subject to the productivity adjustment described in section 1886(b)(3)(B)(iii)(II).''.

(f) HOSPICE CARE.—Subclause (VII) of section 1814(i)(1)(C)(ii) of the Social Security Act (42 U.S.C.

1395f(i)(1)(C)(ii)) is amended by inserting after ''the market basket percentage increase'' the following: ''(which is subject to the productivity adjustment described in section 1886(b)(3)(B)(iii)(II))''.

(g) EFFECTIVE DATE.—The amendments made by subsections (a), (b), (d), and (f) shall apply to annual increases effected for fiscal years beginning with fiscal year 2010.

PART 2—OTHER MEDICARE PART A PROVISIONS

SEC. 1111. PAYMENTS TO SKILLED NURSING FACILITIES.

(a) CHANGE IN RECALIBRATION FACTOR.—

(1) ANALYSIS.—The Secretary of Health and Human Services shall conduct, using calendar year 2006 claims data, an initial analysis comparing total payments under title XVIII of the Social Security Act for skilled nursing facility services under the RUG–53 and under the RUG–44 classification systems.

(2) ADJUSTMENT IN RECALIBRATION FACTOR.—Based on the initial analysis under paragraph (1), the Secretary shall adjust the case mix indexes under section 1888(e)(4)(G)(i) of the Social Security Act (42 U.S.C. 1395yy(e)(4)(G)(i)) for fiscal year 2010 by the appropriate recalibration factor as proposed in the proposed rule for Medicare skilled nurs-

ing facilities issued by such Secretary on May 12, 2009 (74 Federal Register 22214 et seq.).

(b) CHANGE IN PAYMENT FOR NONTHERAPY ANCILLARY (NTA) SERVICES AND THERAPY SERVICES.—

(1) CHANGES UNDER CURRENT SNF CLASSIFICATION SYSTEM.—

(A) IN GENERAL.—Subject to subparagraph (B), the Secretary of Health and Human Services shall, under the system for payment of skilled nursing facility services under section 1888(e) of the Social Security Act (42 U.S.C. 1395yy(e)), increase payment by 10 percent for non-therapy ancillary services (as specified by the Secretary in the notice issued on November 27, 1998 (63 Federal Register 65561 et seq.)) and shall decrease payment for the therapy case mix component of such rates by 5.5 percent.

(B) EFFECTIVE DATE.—The changes in payment described in subparagraph (A) shall apply for days on or after January 1, 2010, and until the Secretary implements an alternative case mix classification system for payment of skilled nursing facility services under section 1888(e) of the Social Security Act (42 U.S.C. 1395yy(e)).

(C) IMPLEMENTATION.—Notwithstanding any other provision of law, the Secretary may implement by program instruction or otherwise the provisions of this paragraph.

(2) CHANGES UNDER A FUTURE SNF CASE MIX CLASSIFICATION SYSTEM.—

(A) ANALYSIS.—

(i) IN GENERAL.—The Secretary of Health and Human Services shall analyze payments for non-therapy ancillary services under a future skilled nursing facility classification system to ensure the accuracy of payment for non-therapy ancillary services. Such analysis shall consider use of appropriate indicators which may include age, physical and mental status, ability to perform activities of daily living, prior nursing home stay, broad RUG category, and a proxy for length of stay.

(ii) APPLICATION.—Such analysis shall be conducted in a manner such that the future skilled nursing facility classification system is implemented to apply to services furnished during a fiscal year beginning with fiscal year 2011.

(B) CONSULTATION.—In conducting the analysis under subparagraph (A), the Secretary shall consult with interested parties, including the Medicare Payment Advisory Commission and other interested stakeholders, to identify appropriate predictors of nontherapy ancillary costs.

(C) RULEMAKING.—The Secretary shall include the result of the analysis under subparagraph (A) in the fiscal year 2011 rulemaking cycle for purposes of implementation beginning for such fiscal year.

(D) IMPLEMENTATION.—Subject to subparagraph (E) and consistent with subparagraph (A)(ii), the Secretary shall implement changes to payments for non-therapy ancillary services (which may include a separate rate component for non-therapy ancillary services and may include use of a model that predicts payment amounts applicable for non-therapy ancillary services) under such future skilled nursing facility services classification system as the Secretary determines appropriate based on the analysis conducted pursuant to subparagraph (A).

(E) BUDGET NEUTRALITY.—The Secretary shall implement changes described in subparagraph (D) in a manner such that the estimated expenditures under such future skilled nursing facility services classification system for a fiscal year beginning with fiscal year 2011 with such changes would be equal to the estimated expenditures that would otherwise occur under title XVIII of the Social Security Act under such future skilled nursing facility services classification system for such year without such changes.

(c) OUTLIER POLICY FOR NTA AND THERAPY.—Section 1888(e) of the Social Security Act (42 U.S.C. 1395yy(e)) is amended by adding at the end the following new paragraph:

''(13) OUTLIERS FOR NTA AND THERAPY.—

''(A) IN GENERAL.—With respect to outliers because of unusual variations in the type or amount of medically necessary care, beginning with October 1, 2010, the Secretary—

''(i) shall provide for an addition or adjustment to the payment amount otherwise made under this section with respect

to non-therapy ancillary services in the case of such outliers; and

''(ii) may provide for such an addition or adjustment to the payment amount otherwise made under this section with respect to therapy services in the case of such outliers.

''(B) OUTLIERS BASED ON AGGREGATE COSTS.—Outlier adjustments or additional payments described in subparagraph (A) shall be based on aggregate costs during a stay in a skilled nursing facility and not on the number of days in such stay.

''(C) BUDGET NEUTRALITY.— The Secretary shall reduce estimated payments that would otherwise be made under the prospective payment system under this subsection with respect to a fiscal year by 2 percent. The total amount of the additional payments or payment adjustments for outliers made under this paragraph with respect to a fiscal year may not exceed 2 percent of the total payments projected or estimated to be made based on the prospective payment system under this subsection for the fiscal year.''.

(d) CONFORMING AMENDMENTS.—Section 1888(e)(8) of such Act (42 U.S.C. 1395yy(e)(8)) is amended—

(1) in subparagraph (A), by inserting ''and adjustment under section 1111(b) of the America's Affordable Health Choices Act of 2009;

(2) in subparagraph (B), by striking ''and'';

(3) in subparagraph (C), by striking the period and inserting ''; and''; and

(4) by adding at the end the following new subparagraph:

''(D) the establishment of outliers under paragraph (13).''.

SEC. 1112. MEDICARE DSH REPORT AND PAYMENT ADJUSTMENTS IN RESPONSE TO COVERAGE EXPANSION.

(a) DSH REPORT.—

(1) IN GENERAL.—Not later than January 1, 2016, the Secretary of Health and Human Services shall submit to Congress a report on Medicare DSH taking into account the impact of the health care reforms carried out under division A in reducing the number of uninsured individuals. The report shall include recommendations relating to the following:

(A) The appropriate amount, targeting, and distribution of Medicare DSH to compensate for higher Medicare costs associated with serving low-income beneficiaries (taking into account variations in the empirical justification for Medicare DSH attributable to hospital characteristics, including bed size), consistent with the original intent of Medicare DSH.

(B) The appropriate amount, targeting, and distribution of Medicare DSH to hospitals given their continued uncompensated care costs, to the extent such costs remain.

(2) COORDINATION WITH MEDICAID DSH REPORT.—The Secretary shall coordinate the report under this subsection with the report on Medicaid DSH under section 1704(a).

(b) PAYMENT ADJUSTMENTS IN RESPONSE TO COVERAGE EXPANSION.—

(1) IN GENERAL.—If there is a significant decrease in the national rate of uninsurance as a result of this Act (as determined under paragraph (2)(A)), then the Secretary of Health and Human Services shall, beginning in fiscal year 2017, implement the following adjustments to Medicare DSH:

(A) The amount of Medicare DSH shall be adjusted based on the recommendations of the report under subsection (a)(1)(A) and shall take into account variations in the empirical justification for Medicare DSH attributable to hospital characteristics, including bed size.

(B) Subject to paragraph (3), increase Medicare DSH for a hospital by an additional amount that is based on the amount of uncompensated care provided by the hospital based on criteria for uncompensated care as determined by the Secretary, which shall exclude bad debt.

(2) SIGNIFICANT DECREASE IN NATIONAL RATE OF UNINSURANCE AS A RESULT OF THIS ACT.—For purposes of this subsection—

(A) IN GENERAL.—There is a ''significant decrease in the national rate of uninsurance as a result of this Act'' if there is a decrease in the national rate of uninsurance (as defined in subparagraph (B)) from 2012 to 2014 that exceeds 8 percentage points.

(B) NATIONAL RATE OF UNINSURANCE DEFINED.—The term ''national rate of uninsurance'' means, for a year, such rate for the under-65 population for the year as deter-

mined and published by the Bureau of the Census in its Current Population Survey in or about September of the succeeding year.

(3) UNCOMPENSATED CARE INCREASE.—

(A) COMPUTATION OF DSH SAVINGS.—For each fiscal year (beginning with fiscal year 2017), the Secretary shall estimate the aggregate reduction in Medicare DSH that will result from the adjustment under paragraph (1)(A).

(B) STRUCTURE OF PAYMENT INCREASE.—The Secretary shall compute the increase in Medicare DSH under paragraph (1)(B) for a fiscal year in accordance with a formula established by the Secretary that provides that—

(i) the aggregate amount of such increase for the fiscal year does not exceed 50 percent of the aggregate reduction in Medicare DSH estimated by the Secretary for such fiscal year; and

(ii) hospitals with higher levels of uncompensated care receive a greater increase.

(c) MEDICARE DSH.—In this section, the term ''Medicare DSH'' means adjustments in payments under

section 1886(d)(5)(F) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(F)) for inpatient hospital services furnished by disproportionate share hospitals.

Subtitle B—Provisions Related to Part B

PART 1—PHYSICIANS' SERVICES

SEC. 1121. SUSTAINABLE GROWTH RATE REFORM.

(a) TRANSITIONAL UPDATE FOR 2010.—Section 1848(d) of the Social Security Act (42 U.S.C. 1395w–4(d)) is amended by adding at the end the following new paragraph:

''(10) UPDATE FOR 2010.—The update to the single conversion factor established in paragraph (1)(C) for 2010 shall be the percentage increase in the MEI (as defined in section 1842(i)(3)) for that year.''.

(b) REBASING SGR USING 2009; LIMITATION ON CUMULATIVE ADJUSTMENT PERIOD.—Section 1848(d)(4) of such Act (42 U.S.C. 1395w–4(d)(4)) is amended—

(1) in subparagraph (B), by striking ''subparagraph (D)'' and inserting ''subparagraphs (D) and (G)''; and

(2) by adding at the end the following new subparagraph:

''(G) REBASING USING 2009 FOR FUTURE UPDATE ADJUSTMENTS.—In determining the update adjustment factor under subparagraph (B) for 2011 and subsequent years—

''(i) the allowed expenditures for 2009 shall be equal to the amount of the actual expenditures for physicians' services during 2009; and

''(ii) the reference in subparagraph (B)(ii)(I) to 'April 1, 1996' shall be treated as a reference to 'January 1, 2009 (or, if later, the first day of the fifth year before the year involved)'.''.

(c) LIMITATION ON PHYSICIANS' SERVICES INCLUDED IN TARGET GROWTH RATE COMPUTATION TO SERVICES COVERED UNDER PHYSICIAN FEE SCHEDULE.—Effective for services furnished on or after January 1, 2009, section 1848(f)(4)(A) of such Act is amended striking ''(such as clinical'' and all that follows through ''in a physician's office'' and inserting ''for which payment under this part is made under the fee schedule under this section, for services for practitioners described in section 1842(b)(18)(C) on a basis related to such fee schedule, or for services described in section 1861(p) (other than

such services when furnished in the facility of a provider of services)''.

(d) ESTABLISHMENT OF SEPARATE TARGET GROWTH RATES FOR CATEGORIES OF SERVICES.—

(1) ESTABLISHMENT OF SERVICE CATEGORIES.—Subsection (j) of section 1848 of the Social Security Act (42 U.S.C. 1395w–4) is amended by adding at the end the following new paragraph:

''(5) SERVICE CATEGORIES.—For services furnished on or after January 1, 2009, each of the following categories of physicians' services (as defined in paragraph (3)) shall be treated as a separate 'service category':

''(A) Evaluation and management services that are procedure codes (for services covered under this title) for—

''(i) services in the category designated Evaluation and Management in the Health Care Common Procedure Coding System (established by the Secretary under subsection (c)(5) as of December 31, 2009, and as subsequently modified by the Secretary); and

''(ii) preventive services (as defined in section 1861(iii)) for which payment is made under this section.

''(B) All other services not described in subparagraph (A).

Service categories established under this paragraph shall apply without regard to the specialty of the physician furnishing the service.''.

(2) ESTABLISHMENT OF SEPARATE CONVERSION FACTORS FOR EACH SERVICE CATEGORY.—Subsection (d)(1) of section 1848 of the Social Security Act (42 U.S.C. 1395w–4) is amended—

(A) in subparagraph (A)—

(i) by designating the sentence beginning ''The conversion factor'' as clause (i) with the heading ''APPLICATION OF SINGLE CONVERSION FACTOR.—'' and with appropriate indentation;

(ii) by striking ''The conversion factor'' and inserting ''Subject to clause (ii), the conversion factor''; and

(iii) by adding at the end the following new clause:

''(ii) APPLICATION OF MULTIPLE CONVERSION FACTORS BEGINNING WITH 2011.—

''(I) IN GENERAL.—In applying clause (i) for years beginning with 2011, separate conversion factors shall be established for each service category of physicians' services (as defined in subsection (j)(5)) and any reference in this section to a conversion factor for such years shall be deemed to be a reference to the conversion factor for each of such categories.

''(II) INITIAL CONVERSION FACTORS.—Such factors for 2011 shall be based upon the single conversion factor for the previous year multiplied by the update established under paragraph (11) for such category for 2011.

''(III) UPDATING OF CONVERSION FACTORS.—Such factor for a service category for a subsequent year shall be based upon the conversion

factor for such category for the previous year and adjusted by the update established for such category under paragraph (11) for the year involved.''; and

(B) in subparagraph (D), by striking ''other physicians' services'' and inserting ''for physicians' services described in the service category described in subsection (j)(5)(B)''.

(3) ESTABLISHING UPDATES FOR CONVERSION FACTORS FOR SERVICE CATEGORIES.—Section 1848(d) of the Social Security Act (42 U.S.C. 1395w–4(d)), as amended by subsection (a), is amended—

(A) in paragraph (4)(C)(iii), by striking ''The allowed'' and inserting ''Subject to paragraph (11)(B), the allowed''; and

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

''(11) UPDATES FOR SERVICE CATEGORIES BEGINNING WITH 2011.—

''(A) IN GENERAL.—In applying paragraph (4) for a year beginning with 2011, the following rules apply:

''(i) APPLICATION OF SEPARATE UPDATE ADJUSTMENTS FOR EACH SERVICE CATEGORY.—Pursuant to paragraph (1)(A)(ii)(I), the update shall be made to the conversion factor for each service category (as defined in subsection (j)(5)) based upon an update adjustment factor for the respective category and year and the update adjustment factor shall be computed, for a year, separately for each service category.

''(ii) COMPUTATION OF ALLOWED AND ACTUAL EXPENDITURES BASED ON SERVICE CATEGORIES.—In computing the prior year adjustment component and the cumulative adjustment component under clauses (i) and (ii) of paragraph (4)(B), the following rules apply:

''(I) APPLICATION BASED ON SERVICE CATEGORIES.—The allowed expenditures and actual expenditures shall be the allowed and actual expenditures for the service category, as determined under subparagraph (B).

''(II) APPLICATION OF CATEGORY SPECIFIC TARGET GROWTH RATE.—The growth rate applied under clause (ii)(II) of such paragraph shall be the target growth rate for the service category involved under subsection (f)(5).

''(B) DETERMINATION OF ALLOWED EXPENDITURES.—In applying paragraph (4) for a year beginning with 2010, notwithstanding subparagraph (C)(iii) of such paragraph, the allowed expenditures for a service category for a year is an amount computed by the Secretary as follows:

''(i) FOR 2010.—For 2010:

''(I) TOTAL 2009 ACTUAL EXPENDITURES FOR ALL SERVICES INCLUDED IN SGR COMPUTATION FOR EACH SERVICE CATEGORY.—Compute total actual expenditures for physicians' services (as defined in subsection (f)(4)(A)) for 2009 for each service category.

''(II) INCREASE BY GROWTH RATE TO OBTAIN 2010 ALLOWED EXPENDITURES FOR SERVICE CAT-

EGORY.—Compute allowed expenditures for the service category for 2010 by increasing the allowed expenditures for the service category for 2009 computed under subclause (I) by the target growth rate for such service category under subsection (f) for 2010.

''(ii) FOR SUBSEQUENT YEARS.—For a subsequent year, take the amount of allowed expenditures for such category for the preceding year (under clause (i) or this clause) and increase it by the target growth rate determined under subsection (f) for such category and year.''.

(4) APPLICATION OF SEPARATE TARGET GROWTH RATES FOR EACH CATEGORY.—

(A) IN GENERAL.—Section 1848(f) of the Social Security Act (42 U.S.C. 1395w–4(f)) is amended by adding at the end the following new paragraph:

''(5) APPLICATION OF SEPARATE TARGET GROWTH RATES FOR EACH SERVICE CATEGORY BEGINNING WITH 2010.—The target growth rate for a year beginning with 2010 shall be computed and applied separately under this subsection for each serv-

ice category (as defined in subsection (j)(5)) and shall be computed using the same method for computing the target growth rate except that the factor described in paragraph (2)(C) for—

''(A) the service category described in subsection (j)(5)(A) shall be increased by 0.02; and

''(B) the service category described in subsection (j)(5)(B) shall be increased by 0.01.''.

(B) USE OF TARGET GROWTH RATES.—Section 1848 of such Act is further amended—

(i) in subsection (d)—

(I) in paragraph (1)(E)(ii), by inserting ''or target'' after ''sustainable''; and

(II) in paragraph (4)(B)(ii)(II), by inserting ''or target'' after ''sustainable''; and

(ii) in the heading of subsection (f), by inserting ''AND TARGET GROWTH RATE'' after ''SUSTAINABLE GROWTH RATE'';

(iii) in subsection (f)(1)—

(I) by striking ''and'' at the end of subparagraph (A);

(II) in subparagraph (B), by inserting ''before 2010'' after ''each succeeding year'' and by striking the period at the end and inserting ''; and''; and

(III) by adding at the end the following new subparagraph:

''(C) November 1 of each succeeding year the target growth rate for such succeeding year and each of the 2 preceding years.''; and

(iv) in subsection (f)(2), in the matter before subparagraph (A), by inserting after ''beginning with 2000'' the following: ''and ending with 2009''.

(e) APPLICATION TO ACCOUNTABLE CARE ORGANIZATION PILOT PROGRAM.—In applying the target growth rate under subsections (d) and (f) of section 1848 of the Social Security Act to services furnished by a practitioner to beneficiaries who are attributable to an accountable care organization under the pilot program provided under section 1866D of such Act, the Secretary of Health and Human Services shall develop, not later than January 1, 2012, for application beginning with 2012, a method that—

(1) allows each such organization to have its own expenditure targets and updates for such practitioners, with respect to beneficiaries who are attributable to that organization, that are consistent with the methodologies described in such subsection (f); and

(2) provides that the target growth rate applicable to other physicians shall not apply to such physicians to the extent that the physicians' services are furnished through the accountable care organization.

In applying paragraph (1), the Secretary of Health and Human Services may apply the difference in the update under such paragraph on a claim-by-claim or lump sum basis and such a payment shall be taken into account under the pilot program.

SEC. 1122. MISVALUED CODES UNDER THE PHYSICIAN FEE SCHEDULE.

(a) IN GENERAL.—Section 1848(c)(2) of the Social Security Act (42 U.S.C. 1395w-4(c)(2)) is amended by adding at the end the following new subparagraphs:

"(K) POTENTIALLY MISVALUED CODES.—

"(i) IN GENERAL.—The Secretary shall—

''(I) periodically identify services as being potentially misvalued using criteria specified in clause (ii); and

''(II) review and make appropriate adjustments to the relative values established under this paragraph for services identified as being potentially misvalued under subclause (I).

''(ii) IDENTIFICATION OF POTENTIALLY MISVALUED CODES.—For purposes of identifying potentially misvalued services pursuant to clause (i)(I), the Secretary shall examine (as the Secretary determines to be appropriate) codes (and families of codes as appropriate) for which there has been the fastest growth; codes (and families of codes as appropriate) that have experienced substantial changes in practice expenses; codes for new technologies or services within an appropriate period (such as three years) after the relative values are initially established for such codes; multiple codes that are frequently billed in conjunction with furnishing a single service; codes with low relative values, particu-

larly those that are often billed multiple times for a single treatment; codes which have not been subject to review since the implementation of the RBRVS (the so-called 'Harvard-valued codes'); and such other codes determined to be appropriate by the Secretary.

''(iii) REVIEW AND ADJUSTMENTS.—

''(I) The Secretary may use existing processes to receive recommendations on the review and appropriate adjustment of potentially misvalued services described clause (i)(II).

''(II) The Secretary may conduct surveys, other data collection activities, studies, or other analyses as the Secretary determines to be appropriate to facilitate the review and appropriate adjustment described in clause (i)(II).

''(III) The Secretary may use analytic contractors to identify and analyze services identified under clause (i)(I), conduct surveys or col-

lect data, and make recommendations on the review and appropriate adjustment of services described in clause (i)(II).

''(IV) The Secretary may coordinate the review and appropriate adjustment described in clause (i)(II) with the periodic review described in subparagraph (B).

''(V) As part of the review and adjustment described in clause (i)(II), including with respect to codes with low relative values described in clause (ii), the Secretary may make appropriate coding revisions (including using existing processes for consideration of coding changes) which may include consolidation of individual services into bundled codes for payment under the fee schedule under subsection (b).

''(VI) The provisions of subparagraph (B)(ii)(II) shall apply to adjustments to relative value units made pursuant to this subparagraph in the

same manner as such provisions apply to adjustments under subparagraph (B)(ii)(II).

''(L) VALIDATING RELATIVE VALUE UNITS.—

''(i) IN GENERAL.—The Secretary shall establish a process to validate relative value units under the fee schedule under subsection (b).

''(ii) COMPONENTS AND ELEMENTS OF WORK.—The process described in clause (i) may include validation of work elements (such as time, mental effort and professional judgment, technical skill and physical effort, and stress due to risk) involved with furnishing a service and may include validation of the pre, post, and intra-service components of work.

''(iii) SCOPE OF CODES.—The validation of work relative value units shall include a sampling of codes for services that is the same as the codes listed under subparagraph (K)(ii)

''(iv) METHODS.—The Secretary may conduct the validation under this subpara-

graph using methods described in subclauses (I) through (V) of subparagraph (K)(iii) as the Secretary determines to be appropriate.

''(v) ADJUSTMENTS.—The Secretary shall make appropriate adjustments to the work relative value units under the fee schedule under subsection (b). The provisions of subparagraph (B)(ii)(II) shall apply to adjustments to relative value units made pursuant to this subparagraph in the same manner as such provisions apply to adjustments under subparagraph (B)(ii)(II).''.

(b) IMPLEMENTATION.—

(1) FUNDING.—For purposes of carrying out the provisions of subparagraphs (K) and (L) of 1848(c)(2) of the Social Security Act, as added by subsection (a), in addition to funds otherwise available, out of any funds in the Treasury not otherwise appropriated, there are appropriated to the Secretary of Health and Human Services for the Center for Medicare & Medicaid Services Program Management Account $20,000,000 for fiscal year 2010 and each subsequent fiscal year. Amounts appropriated

under this paragraph for a fiscal year shall be available until expended.

(2) ADMINISTRATION.—

(A) Chapter 35 of title 44, United States Code and the provisions of the Federal Advisory Committee Act (5 U.S.C. App.) shall not apply to this section or the amendment made by this section.

(B) Notwithstanding any other provision of law, the Secretary may implement subparagraphs (K) and (L) of 1848(c)(2) of the Social Security Act, as added by subsection (a), by program instruction or otherwise.

(C) Section 4505(d) of the Balanced Budget Act of 1997 is repealed.

(D) Except for provisions related to confidentiality of information, the provisions of the Federal Acquisition Regulation shall not apply to this section or the amendment made by this section.

(3) FOCUSING CMS RESOURCES ON POTENTIALLY OVERVALUED CODES.—Section 1868(a) of the Social Security Act (42 1395ee(a)) is repealed.

SEC. 1123. PAYMENTS FOR EFFICIENT AREAS.

Section 1833 of the Social Security Act (42 U.S.C. 1395l) is amended by adding at the end the following new subsection:

''(x) INCENTIVE PAYMENTS FOR EFFICIENT AREAS.—

''(1) IN GENERAL.—In the case of services furnished under the physician fee schedule under section 1848 on or after January 1, 2011, and before January 1, 2013, by a supplier that is paid under such fee schedule in an efficient area (as identified under paragraph (2)), in addition to the amount of payment that would otherwise be made for such services under this part, there also shall be paid (on a monthly or quarterly basis) an amount equal to 5 percent of the payment amount for the services under this part.

''(2) IDENTIFICATION OF EFFICIENT AREAS.—

''(A) IN GENERAL.—Based upon available data, the Secretary shall identify those counties or equivalent areas in the United States in the lowest fifth percentile of utilization based on per capita spending under this part and part A for services provided in the most recent year for which data are available as of the date of the enactment of this subsection, as standardized to

eliminate the effect of geographic adjustments in payment rates.

"(B) IDENTIFICATION OF COUNTIES WHERE SERVICE IS FURNISHED..—For purposes of paying the additional amount specified in paragraph (1), if the Secretary uses the 5-digit postal ZIP Code where the service is furnished, the dominant county of the postal ZIP Code (as determined by the United States Postal Service, or otherwise) shall be used to determine whether the postal ZIP Code is in a county described in subparagraph (A).

"(C) LIMITATION ON REVIEW.—There shall be no administrative or judicial review under section 1869, 1878, or otherwise, respecting—

"(i) the identification of a county or other area under subparagraph (A); or

"(ii) the assignment of a postal ZIP Code to a county or other area under subparagraph (B).

"(D) PUBLICATION OF LIST OF COUNTIES; POSTING ON WEBSITE.—With respect to a year for which a county or area is identified under this paragraph, the Secretary shall identify

such counties or areas as part of the proposed and final rule to implement the physician fee schedule under section 1848 for the applicable year. The Secretary shall post the list of counties identified under this paragraph on the Internet website of the Centers for Medicare & Medicaid Services.''.

SEC. 1124. MODIFICATIONS TO THE PHYSICIAN QUALITY REPORTING INITIATIVE (PQRI).

(a) FEEDBACK.—Section 1848(m)(5) of the Social Security Act (42 U.S.C. 1395w–4(m)(5)) is amended by adding at the end the following new subparagraph:

''(H) FEEDBACK.—The Secretary shall provide timely feedback to eligible professionals on the performance of the eligible professional with respect to satisfactorily submitting data on quality measures under this subsection.''.

(b) APPEALS.—Such section is further amended—

(1) in subparagraph (E), by striking ''There shall be'' and inserting ''Subject to subparagraph (I), there shall be''; and

(2) by adding at the end the following new subparagraph:

''(I) INFORMAL APPEALS PROCESS.—Notwithstanding subparagraph (E), by not later

than January 1, 2011, the Secretary shall establish and have in place an informal process for eligible professionals to appeal the determination that an eligible professional did not satisfactorily submit data on quality measures under this subsection.''.

(c) INTEGRATION OF PHYSICIAN QUALITY REPORTING AND EHR REPORTING.—Section 1848(m) of such Act is amended by adding at the end the following new paragraph:

''(7) INTEGRATION OF PHYSICIAN QUALITY REPORTING AND EHR REPORTING.—Not later than January 1, 2012, the Secretary shall develop a plan to integrate clinical reporting on quality measures under this subsection with reporting requirements under subsection (o) relating to the meaningful use of electronic health records. Such integration shall consist of the following:

''(A) The development of measures, the reporting of which would both demonstrate—

''(i) meaningful use of an electronic health record for purposes of subsection (o); and

''(ii) clinical quality of care furnished to an individual.

''(B) The collection of health data to identify deficiencies in the quality and coordination of care for individuals eligible for benefits under this part.

''(C) Such other activities as specified by the Secretary.''.

(d) EXTENSION OF INCENTIVE PAYMENTS.—Section 1848(m)(1) of such Act (42 U.S.C. 1395w–4(m)(1)) is amended—

(1) in subparagraph (A), by striking ''2010'' and inserting ''2012''; and

(2) in subparagraph (B)(ii), by striking ''2009 and 2010'' and inserting ''for each of the years 2009 through 2012''.

SEC. 1125. ADJUSTMENT TO MEDICARE PAYMENT LOCALITIES.

(a) IN GENERAL.—Section 1848(e) of the Social Security Act (42 U.S.C.1395w–4(e)) is amended by adding at the end the following new paragraph:

''(6) TRANSITION TO USE OF MSAS AS FEE SCHEDULE AREAS IN CALIFORNIA.—

''(A) IN GENERAL.—

''(i) REVISION.—Subject to clause (ii) and notwithstanding the previous provisions of this subsection, for services fur-

nished on or after January 1, 2011, the Secretary shall revise the fee schedule areas used for payment under this section applicable to the State of California using the Metropolitan Statistical Area (MSA) iterative Geographic Adjustment Factor methodology as follows:

''(I) The Secretary shall configure the physician fee schedule areas using the Core-Based Statistical Areas-Metropolitan Statistical Areas (each in this paragraph referred to as an 'MSA'), as defined by the Director of the Office of Management and Budget, as the basis for the fee schedule areas. The Secretary shall employ an iterative process to transition fee schedule areas. First, the Secretary shall list all MSAs within the State by Geographic Adjustment Factor described in paragraph (2) (in this paragraph referred to as a 'GAF') in descending order. In the first iteration, the Secretary shall compare the GAF of the highest cost MSA in the State

to the weighted-average GAF of the group of remaining MSAs in the State. If the ratio of the GAF of the highest cost MSA to the weighted-average GAF of the rest of State is 1.05 or greater then the highest cost MSA becomes a separate fee schedule area.

''(II) In the next iteration, the Secretary shall compare the MSA of the second-highest GAF to the weighted-average GAF of the group of remaining MSAs. If the ratio of the second-highest MSA's GAF to the weighted-average of the remaining lower cost MSAs is 1.05 or greater, the second-highest MSA becomes a separate fee schedule area. The iterative process continues until the ratio of the GAF of the highest-cost remaining MSA to the weighted-average of the remaining lower-cost MSAs is less than 1.05, and the remaining group of lower cost MSAs form a single fee schedule area, If two MSAs

have identical GAFs, they shall be combined in the iterative comparison.

''(ii) TRANSITION.—For services furnished on or after January 1, 2011, and before January 1, 2016, in the State of California, after calculating the work, practice expense, and malpractice geographic indices described in clauses (i), (ii), and (iii) of paragraph (1)(A) that would otherwise apply through application of this paragraph, the Secretary shall increase any such index to the county-based fee schedule area value on December 31, 2009, if such index would otherwise be less than the value on January 1, 2010.

''(B) SUBSEQUENT REVISIONS.—

''(i) PERIODIC REVIEW AND ADJUSTMENTS IN FEE SCHEDULE AREAS.—Subsequent to the process outlined in paragraph (1)(C), not less often than every three years, the Secretary shall review and update the California Rest-of-State fee schedule area using MSAs as defined by the Director of the Office of Management and

Budget and the iterative methodology described in subparagraph (A)(i).

''(ii) LINK WITH GEOGRAPHIC INDEX DATA REVISION.—The revision described in clause (i) shall be made effective concurrently with the application of the periodic review of the adjustment factors required under paragraph (1)(C) for California for 2012 and subsequent periods. Upon request, the Secretary shall make available to the public any county-level or MSA derived data used to calculate the geographic practice cost index.

''(C) REFERENCES TO FEE SCHEDULE AREAS.—Effective for services furnished on or after January 1, 2010, for the State of California, any reference in this section to a fee schedule area shall be deemed a reference to an MSA in the State.''.

(b) CONFORMING AMENDMENT TO DEFINITION OF FEE SCHEDULE AREA.—Section 1848(j)(2) of the Social Security Act (42 U.S.C. 1395w(j)(2)) is amended by striking ''The term'' and inserting ''Except as provided in subsection (e)(6)(C), the term''.

PART 2—MARKET BASKET UPDATES

SEC. 1131. INCORPORATING PRODUCTIVITY IMPROVEMENTS INTO MARKET BASKET UPDATES THAT DO NOT ALREADY INCORPORATE SUCH IMPROVEMENTS.

(a) OUTPATIENT HOSPITALS.—

(1) IN GENERAL.—The first sentence of section 1833(t)(3)(C)(iv) of the Social Security Act (42 U.S.C. 1395l(t)(3)(C)(iv)) is amended—

(A) by inserting ''(which is subject to the productivity adjustment described in subclause (II) of such section)'' after ''1886(b)(3)(B)(iii)''; and

(B) by inserting ''(but not below 0)'' after ''reduced''.

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall apply to increase factors for services furnished in years beginning with 2010.

(b) AMBULANCE SERVICES.—Section 1834(l)(3)(B) of such Act (42 U.S.C. 1395m(l)(3)(B))) is amended by inserting before the period at the end the following: ''and, in the case of years beginning with 2010, subject to the productivity adjustment described in section 1886(b)(3)(B)(iii)(II)''.

(c) AMBULATORY SURGICAL CENTER SERVICES.—Section 1833(i)(2)(D) of such Act (42 U.S.C. 1395l(i)(2)(D)) is amended—

(1) by redesignating clause (v) as clause (vi); and

(2) by inserting after clause (iv) the following new clause:

''(v) In implementing the system described in clause (i), for services furnished during 2010 or any subsequent year, to the extent that an annual percentage change factor applies, such factor shall be subject to the productivity adjustment described in section 1886(b)(3)(B)(iii)(II).''.

(d) LABORATORY SERVICES.—Section 1833(h)(2)(A)) of such Act (42 U.S.C. 1395l(h)(2)(A)) is amended—

(1) in clause (i), by striking ''for each of years 2009 through 2013'' and inserting ''for 2009''; and

(2) clause (ii)—

(A) by striking ''and'' at the end of subclause (III);

(B) by striking the period at the end of subclause (IV) and inserting ''; and''; and

(C) by adding at the end the following new subclause:

''(V) the annual adjustment in the fee schedules determined under clause (i) for years beginning with 2010 shall be subject to the productivity adjustment described in section 1886(b)(3)(B)(iii)(II).''.

(e) CERTAIN DURABLE MEDICAL EQUIPMENT.—Section 1834(a)(14) of such Act (42 U.S.C. 1395m(a)(14)) is amended—

(1) in subparagraph (K), by inserting before the semicolon at the end the following: '', subject to the productivity adjustment described in section 1886(b)(3)(B)(iii)(II)'';

(2) in subparagraph (L)(i), by inserting after ''June 2013,'' the following: ''subject to the productivity adjustment described in section 1886(b)(3)(B)(iii)(II),'';

(3) in subparagraph (L)(ii), by inserting after ''June 2013'' the following: '', subject to the productivity adjustment described in section 1886(b)(3)(B)(iii)(II)''; and

(4) in subparagraph (M), by inserting before the period at the end the following: '', subject to the productivity adjustment described in section 1886(b)(3)(B)(iii)(II)''.

PART 3—OTHER PROVISIONS

SEC. 1141. RENTAL AND PURCHASE OF POWER-DRIVEN WHEELCHAIRS.

(a) IN GENERAL.—Section 1834(a)(7)(A)(iii) of the Social Security Act (42 U.S.C. 1395m(a)(7)(A)(iii)) is amended—

(1) in the heading, by inserting ''CERTAIN COMPLEX REHABILITATIVE'' after ''OPTION FOR''; and

(2) by striking ''power-driven wheelchair'' and inserting ''complex rehabilitative power-driven wheelchair recognized by the Secretary as classified within group 3 or higher''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall take effect on January 1, 2011, and shall apply to power-driven wheelchairs furnished on or after such date. Such amendments shall not apply to contracts entered into under section 1847 of the Social Security Act (42 U.S.C. 1395w–3) pursuant to a bid submitted under such section before October 1, 2010, under subsection (a)(1)(B)(i)(I) of such section.

SEC. 1142. EXTENSION OF PAYMENT RULE FOR BRACHYTHERAPY.

Section 1833(t)(16)(C) of the Social Security Act (42 U.S.C. 1395l(t)(16)(C)), as amended by section 142 of the Medicare Improvements for Patients and Providers Act of 2008 (Public Law 110–275), is amended by striking, the

first place it appears, ''January 1, 2010'' and inserting ''January 1, 2012''.

SEC. 1143. HOME INFUSION THERAPY REPORT TO CONGRESS.

Not later than 12 months after the date of enactment of this Act, the Medicare Payment Advisory Commission shall submit to Congress a report on the following:

(1) The scope of coverage for home infusion therapy in the fee-for-service Medicare program under title XVIII of the Social Security Act, Medicare Advantage under part C of such title, the veteran's health care program under chapter 17 of title 38, United States Code, and among private payers, including an analysis of the scope of services provided by home infusion therapy providers to their patients in such programs.

(2) The benefits and costs of providing such coverage under the Medicare program, including a calculation of the potential savings achieved through avoided or shortened hospital and nursing home stays as a result of Medicare coverage of home infusion therapy.

(3) An assessment of sources of data on the costs of home infusion therapy that might be used

to construct payment mechanisms in the Medicare program.

(4) Recommendations, if any, on the structure of a payment system under the Medicare program for home infusion therapy, including an analysis of the payment methodologies used under Medicare Advantage plans and private health plans for the provision of home infusion therapy and their applicability to the Medicare program.

SEC. 1144. REQUIRE AMBULATORY SURGICAL CENTERS (ASCS) TO SUBMIT COST DATA AND OTHER DATA.

(a) COST REPORTING.—

(1) IN GENERAL.—Section 1833(i) of the Social Security Act (42 U.S.C. 1395l(i)) is amended by adding at the end the following new paragraph:

''(8) The Secretary shall require, as a condition of the agreement described in section 1832(a)(2)(F)(i), the submission of such cost report as the Secretary may specify, taking into account the requirements for such reports under section 1815 in the case of a hospital.''.

(2) DEVELOPMENT OF COST REPORT.—Not later than 3 years after the date of the enactment of this Act, the Secretary of Health and Human Services shall develop a cost report form for use

under section 1833(i)(8) of the Social Security Act, as added by paragraph (1).

(3) AUDIT REQUIREMENT.—The Secretary shall provide for periodic auditing of cost reports submitted under section 1833(i)(8) of the Social Security Act, as added by paragraph (1).

(4) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to agreements applicable to cost reporting periods beginning 18 months after the date the Secretary develops the cost report form under paragraph (2).

(b) ADDITIONAL DATA ON QUALITY.—

(1) IN GENERAL.—Section 1833(i)(7) of such Act (42 U.S.C. 1395l(i)(7)) is amended—

(A) in subparagraph (B), by inserting ''subject to subparagraph (C),'' after ''may otherwise provide,''; and

(B) by adding at the end the following new subparagraph:

''(C) Under subparagraph (B) the Secretary shall require the reporting of such additional data relating to quality of services furnished in an ambulatory surgical facility, including data on health care associated infections, as the Secretary may specify.''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall to reporting for years beginning with 2012.

SEC. 1145. TREATMENT OF CERTAIN CANCER HOSPITALS.

Section 1833(t) of the Social Security Act (42 U.S.C. 1395l(t)) is amended by adding at the end the following new paragraph:

''(18) AUTHORIZATION OF ADJUSTMENT FOR CANCER HOSPITALS.—

''(A) STUDY.—The Secretary shall conduct a study to determine if, under the system under this subsection, costs incurred by hospitals described in section 1886(d)(1)(B)(v) with respect to ambulatory payment classification groups exceed those costs incurred by other hospitals furnishing services under this subsection (as determined appropriate by the Secretary).

''(B) AUTHORIZATION OF ADJUSTMENT.—Insofar as the Secretary determines under subparagraph (A) that costs incurred by hospitals described in section 1886(d)(1)(B)(v) exceed those costs incurred by other hospitals furnishing services under this subsection, the Secretary shall provide for an appropriate adjustment under paragraph (2)(E) to reflect those

higher costs effective for services furnished on or after January 1, 2011.''.

SEC. 1146. MEDICARE IMPROVEMENT FUND.

Section 1898(b)(1)(A) of the Social Security Act (42 U.S.C. 1395iii(b)(1)(A)) is amended to read as follows:

''(A) the period beginning with fiscal year 2011 and ending with fiscal year 2019, $8,000,000,000; and''.

SEC. 1147. PAYMENT FOR IMAGING SERVICES.

(a) ADJUSTMENT IN PRACTICE EXPENSE TO REFLECT HIGHER PRESUMED UTILIZATION.—Section 1848 of the Social Security Act (42 U.S.C. 1395w) is amended—

(1) in subsection (b)(4)—

(A) in subparagraph (B), by striking ''subparagraph (A)'' and inserting ''this paragraph''; and

(B) by adding at the end the following new subparagraph:

''(C) ADJUSTMENT IN PRACTICE EXPENSE TO REFLECT HIGHER PRESUMED UTILIZATION.—In computing the number of practice expense relative value units under subsection (c)(2)(C)(ii) with respect to advanced diagnostic imaging services (as defined in section

1834(e)(1)(B)) , the Secretary shall adjust such number of units so it reflects a 75 percent (rather than 50 percent) presumed rate of utilization of imaging equipment.''; and

(2) in subsection (c)(2)(B)(v)(II), by inserting ''AND OTHER PROVISIONS'' after ''OPD PAYMENT CAP''.

(b) ADJUSTMENT IN TECHNICAL COMPONENT ''DISCOUNT'' ON SINGLE-SESSION IMAGING TO CONSECUTIVE BODY PARTS.—Section 1848(b)(4) of such Act is further amended by adding at the end the following new subparagraph:

''(D) ADJUSTMENT IN TECHNICAL COMPONENT DISCOUNT ON SINGLE-SESSION IMAGING INVOLVING CONSECUTIVE BODY PARTS.—The Secretary shall increase the reduction in expenditures attributable to the multiple procedure payment reduction applicable to the technical component for imaging under the final rule published by the Secretary in the Federal Register on November 21, 2005 (part 405 of title 42, Code of Federal Regulations) from 25 percent to 50 percent.''.

(c) EFFECTIVE DATE.—Except as otherwise provided, this section, and the amendments made by this sec-

tion, shall apply to services furnished on or after January 1, 2011.

SEC. 1148. DURABLE MEDICAL EQUIPMENT PROGRAM IMPROVEMENTS.

(a) WAIVER OF SURETY BOND REQUIREMENT.—Section 1834(a)(16) of the Social Security Act (42 U.S.C. 1395m(a)(16)) is amended by adding at the end the following: ''The requirement for a surety bond described in subparagraph (B) shall not apply in the case of a pharmacy (i) that has been enrolled under section 1866(j) as a supplier of durable medical equipment, prosthetics, orthotics, and supplies and has been issued (which may include renewal of) a provider number (as described in the first sentence of this paragraph) for at least 5 years, and (ii) for which a final adverse action (as defined in section 424.57(a) of title 42, Code of Federal Regulations) has never been imposed.''.

(b) ENSURING SUPPLY OF OXYGEN EQUIPMENT .—

(1) IN GENERAL.—Section 1834(a)(5)(F) of the Social Security Act (42 U.S.C. 1395m(a)(5)(F)) is amended—

(A) in clause (ii), by striking ''After the'' and inserting ''Except as provided in clause (iii), after the''; and

(B) by adding at the end the following new clause:

''(iii) CONTINUATION OF SUPPLY.—In the case of a supplier furnishing such equipment to an individual under this subsection as of the 27th month of the 36 months described in clause (i), the supplier furnishing such equipment as of such month shall continue to furnish such equipment to such individual (either directly or though arrangements with other suppliers of such equipment) during any subsequent period of medical need for the remainder of the reasonable useful lifetime of the equipment, as determined by the Secretary, regardless of the location of the individual, unless another supplier has accepted responsibility for continuing to furnish such equipment during the remainder of such period.''.

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall take effect as of the date of the enactment of this Act and shall apply to the furnishing of equipment to individuals for whom the 27th month of a continuous period of use of oxygen

equipment described in section 1834(a)(5)(F) of the Social Security Act occurs on or after July 1, 2010.

(c) TREATMENT OF CURRENT ACCREDITATION APPLICATIONS.—Section 1834(a)(20)(F) of such Act (42 U.S.C. 1395m(a)(20)(F)) is amended—

(1) in clause (i)—

(A) by striking ''clause (ii)'' and inserting ''clauses (ii) and (iii)''; and

(B) by striking ''and'' at the end;

(2) by striking the period at the end of clause (ii)(II) and by inserting ''; and''; and

(3) by adding at the end the following:

''(iii) the requirement for accreditation described in clause (i) shall not apply for purposes of supplying diabetic testing supplies, canes, and crutches in the case of a pharmacy that is enrolled under section 1866(j) as a supplier of durable medical equipment, prosthetics, orthotics, and supplies.

Any supplier that has submitted an application for accreditation before August 1, 2009, shall be deemed as meeting applicable standards and accreditation requirement under this subparagraph until such time as the independent ac-

creditation organization takes action on the supplier's application.''.

(d) RESTORING 36-MONTH OXYGEN RENTAL PERIOD IN CASE OF SUPPLIER BANKRUPTCY FOR CERTAIN INDIVIDUALS.—Section 1834(a)(5)(F) of such Act (42 U.S.C. 1395m(a)(5)(F)) is amended by adding at the end the following new clause:

''(iii) EXCEPTION FOR BANKRUPTCY.—If a supplier of oxygen to an individual is declared bankrupt and its assets are liquidated and at the time of such declaration and liquidation more than 24 months of rental payments have been made, the individual may begin under this subparagraph a new 36-month rental period with another supplier of oxygen.''.

SEC. 1149. MEDPAC STUDY AND REPORT ON BONE MASS MEASUREMENT.

(a) IN GENERAL.—The Medicare Payment Advisory Commission shall conduct a study regarding bone mass measurement, including computed tomography, duel-energy x-ray absorptriometry, and vertebral fracture assessment. The study shall focus on the following:

(1) An assessment of the adequacy of Medicare payment rates for such services, taking into account

costs of acquiring the necessary equipment, professional work time, and practice expense costs.

(2) The impact of Medicare payment changes since 2006 on beneficiary access to bone mass measurement benefits in general and in rural and minority communities specifically.

(3) A review of the clinically appropriate and recommended use among Medicare beneficiaries and how usage rates among such beneficiaries compares to such recommendations.

(4) In conjunction with the findings under (3), recommendations, if necessary, regarding methods for reaching appropriate use of bone mass measurement studies among Medicare beneficiaries.

(b) REPORT.—The Commission shall submit a report to the Congress, not later than 9 months after the date of the enactment of this Act, containing a description of the results of the study conducted under subsection (a) and the conclusions and recommendations, if any, regarding each of the issues described in paragraphs (1), (2) (3) and (4) of such subsection.

Subtitle C—Provisions Related to Medicare Parts A and B

SEC. 1151. REDUCING POTENTIALLY PREVENTABLE HOSPITAL READMISSIONS.

(a) HOSPITALS.—

(1) IN GENERAL.—Section 1886 of the Social Security Act (42 U.S.C. 1395ww), as amended by section 1103(a), is amended by adding at the end the following new subsection:

''(p) ADJUSTMENT TO HOSPITAL PAYMENTS FOR EXCESS READMISSIONS.—

''(1) IN GENERAL.—With respect to payment for discharges from an applicable hospital (as defined in paragraph (5)(C)) occurring during a fiscal year beginning on or after October 1, 2011, in order to account for excess readmissions in the hospital, the Secretary shall reduce the payments that would otherwise be made to such hospital under subsection (d) (or section 1814(b)(3), as the case may be) for such a discharge by an amount equal to the product of—

''(A) the base operating DRG payment amount (as defined in paragraph (2)) for the discharge; and

''(B) the adjustment factor (described in paragraph (3)(A)) for the hospital for the fiscal year.

''(2) BASE OPERATING DRG PAYMENT AMOUNT.—

''(A) IN GENERAL.—Except as provided in subparagraph (B), for purposes of this subsection, the term 'base operating DRG payment amount' means, with respect to a hospital for a fiscal year, the payment amount that would otherwise be made under subsection (d) for a discharge if this subsection did not apply, reduced by any portion of such amount that is attributable to payments under subparagraphs (B) and (F) of paragraph (5).

''(B) ADJUSTMENTS.—For purposes of subparagraph (A), in the case of a hospital that is paid under section 1814(b)(3), the term 'base operating DRG payment amount' means the payment amount under such section.

''(3) ADJUSTMENT FACTOR.—

''(A) IN GENERAL.—For purposes of paragraph (1), the adjustment factor under this paragraph for an applicable hospital for a fiscal year is equal to the greater of—

''(i) the ratio described in subparagraph (B) for the hospital for the applicable period (as defined in paragraph (5)(D)) for such fiscal year; or

''(ii) the floor adjustment factor specified in subparagraph (C).

''(B) RATIO.—The ratio described in this subparagraph for a hospital for an applicable period is equal to 1 minus the ratio of—

''(i) the aggregate payments for excess readmissions (as defined in paragraph (4)(A)) with respect to an applicable hospital for the applicable period; and

''(ii) the aggregate payments for all discharges (as defined in paragraph (4)(B)) with respect to such applicable hospital for such applicable period.

''(C) FLOOR ADJUSTMENT FACTOR.—For purposes of subparagraph (A), the floor adjustment factor specified in this subparagraph for—

''(i) fiscal year 2012 is 0.99;

''(ii) fiscal year 2013 is 0.98;

''(iii) fiscal year 2014 is 0.97; or

''(iv) a subsequent fiscal year is 0.95.

''(4) AGGREGATE PAYMENTS, EXCESS READMISSION RATIO DEFINED.—For purposes of this subsection:

''(A) AGGREGATE PAYMENTS FOR EXCESS READMISSIONS.—The term 'aggregate payments for excess readmissions' means, for a hospital for a fiscal year, the sum, for applicable conditions (as defined in paragraph (5)(A)), of the product, for each applicable condition, of—

''(i) the base operating DRG payment amount for such hospital for such fiscal year for such condition;

''(ii) the number of admissions for such condition for such hospital for such fiscal year; and

''(iii) the excess readmissions ratio (as defined in subparagraph (C)) for such hospital for the applicable period for such fiscal year minus 1.

''(B) AGGREGATE PAYMENTS FOR ALL DISCHARGES.—The term 'aggregate payments for all discharges' means, for a hospital for a fiscal year, the sum of the base operating DRG payment amounts for all discharges for all conditions from such hospital for such fiscal year.

''(C) EXCESS READMISSION RATIO.—

''(i) IN GENERAL.—Subject to clauses (ii) and (iii), the term 'excess readmissions ratio' means, with respect to an applicable condition for a hospital for an applicable period, the ratio (but not less than 1.0) of—

''(I) the risk adjusted readmissions based on actual readmissions, as determined consistent with a readmission measure methodology that has been endorsed under paragraph (5)(A)(ii)(I), for an applicable hospital for such condition with respect to the applicable period; to

''(II) the risk adjusted expected readmissions (as determined consistent with such a methodology) for such hospital for such condition with respect to such applicable period.

''(ii) EXCLUSION OF CERTAIN READMISSIONS.—For purposes of clause (i), with respect to a hospital, excess readmissions shall not include readmissions for an applicable condition for which there are

fewer than a minimum number (as determined by the Secretary) of discharges for such applicable condition for the applicable period and such hospital.

''(iii) ADJUSTMENT.—In order to promote a reduction over time in the overall rate of readmissions for applicable conditions, the Secretary may provide, beginning with discharges for fiscal year 2014, for the determination of the excess readmissions ratio under subparagraph (C) to be based on a ranking of hospitals by readmission ratios (from lower to higher readmission ratios) normalized to a benchmark that is lower than the 50th percentile.

''(5) DEFINITIONS.—For purposes of this subsection:

''(A) APPLICABLE CONDITION.—The term 'applicable condition' means, subject to subparagraph (B), a condition or procedure selected by the Secretary among conditions and procedures for which—

''(i) readmissions (as defined in subparagraph (E)) that represent conditions or procedures that are high volume or high

expenditures under this title (or other criteria specified by the Secretary); and

"(ii) measures of such readmissions—

"(I) have been endorsed by the entity with a contract under section 1890(a); and

"(II) such endorsed measures have appropriate exclusions for readmissions that are unrelated to the prior discharge (such as a planned readmission or transfer to another applicable hospital).

"(B) EXPANSION OF APPLICABLE CONDITIONS.—Beginning with fiscal year 2013, the Secretary shall expand the applicable conditions beyond the 3 conditions for which measures have been endorsed as described in subparagraph (A)(ii)(I) as of the date of the enactment of this subsection to the additional 4 conditions that have been so identified by the Medicare Payment Advisory Commission in its report to Congress in June 2007 and to other conditions and procedures which may include an all-condition measure of readmissions, as determined appropriate by the Secretary. In expanding

such applicable conditions, the Secretary shall seek the endorsement described in subparagraph (A)(ii)(I) but may apply such measures without such an endorsement.

''(C) APPLICABLE HOSPITAL.—The term 'applicable hospital' means a subsection (d) hospital or a hospital that is paid under section 1814(b)(3).

''(D) APPLICABLE PERIOD.—The term 'applicable period' means, with respect to a fiscal year, such period as the Secretary shall specify for purposes of determining excess readmissions.

''(E) READMISSION.—The term 'readmission' means, in the case of an individual who is discharged from an applicable hospital, the admission of the individual to the same or another applicable hospital within a time period specified by the Secretary from the date of such discharge. Insofar as the discharge relates to an applicable condition for which there is an endorsed measure described in subparagraph (A)(ii)(I), such time period (such as 30 days) shall be consistent with the time period specified for such measure.

''(6) LIMITATIONS ON REVIEW.—There shall be no administrative or judicial review under section 1869, section 1878, or otherwise of—

''(A) the determination of base operating DRG payment amounts;

''(B) the methodology for determining the adjustment factor under paragraph (3), including excess readmissions ratio under paragraph (4)(C), aggregate payments for excess readmissions under paragraph (4)(A), and aggregate payments for all discharges under paragraph (4)(B), and applicable periods and applicable conditions under paragraph (5);

''(C) the measures of readmissions as described in paragraph (5)(A)(ii); and

''(D) the determination of a targeted hospital under paragraph (8)(B)(i), the increase in payment under paragraph (8)(B)(ii), the aggregate cap under paragraph (8)(C)(i), the hospital-specific limit under paragraph (8)(C)(ii), and the form of payment made by the Secretary under paragraph (8)(D).

''(7) MONITORING INAPPROPRIATE CHANGES IN ADMISSIONS PRACTICES.—The Secretary shall monitor the activities of applicable hospitals to determine

if such hospitals have taken steps to avoid patients at risk in order to reduce the likelihood of increasing readmissions for applicable conditions. If the Secretary determines that such a hospital has taken such a step, after notice to the hospital and opportunity for the hospital to undertake action to alleviate such steps, the Secretary may impose an appropriate sanction.

''(8) ASSISTANCE TO CERTAIN HOSPITALS.—

''(A) IN GENERAL.—For purposes of providing funds to applicable hospitals to take steps described in subparagraph (E) to address factors that may impact readmissions of individuals who are discharged from such a hospital, for fiscal years beginning on or after October 1, 2011, the Secretary shall make a payment adjustment for a hospital described in subparagraph (B), with respect to each such fiscal year, by a percent estimated by the Secretary to be consistent with subparagraph (C).

''(B) TARGETED HOSPITALS.—Subparagraph (A) shall apply to an applicable hospital that—

''(i) received (or, in the case of an 1814(b)(3) hospital, otherwise would have

been eligible to receive) $10,000,000 or more in disproportionate share payments using the latest available data as estimated by the Secretary; and

''(ii) provides assurances satisfactory to the Secretary that the increase in payment under this paragraph shall be used for purposes described in subparagraph (E).

''(C) CAPS.—

''(i) AGGREGATE CAP.—The aggregate amount of the payment adjustment under this paragraph for a fiscal year shall not exceed 5 percent of the estimated difference in the spending that would occur for such fiscal year with and without application of the adjustment factor described in paragraph (3) and applied pursuant to paragraph (1).

''(ii) HOSPITAL-SPECIFIC LIMIT.—The aggregate amount of the payment adjustment for a hospital under this paragraph shall not exceed the estimated difference in spending that would occur for such fiscal year for such hospital with and without ap-

plication of the adjustment factor described in paragraph (3) and applied pursuant to paragraph (1).

"(D) FORM OF PAYMENT.—The Secretary may make the additional payments under this paragraph on a lump sum basis, a periodic basis, a claim by claim basis, or otherwise.

"(E) USE OF ADDITIONAL PAYMENT.—Funding under this paragraph shall be used by targeted hospitals for transitional care activities designed to address the patient noncompliance issues that result in higher than normal readmission rates, such as one or more of the following:

"(i) Providing care coordination services to assist in transitions from the targeted hospital to other settings.

"(ii) Hiring translators and interpreters.

"(iii) Increasing services offered by discharge planners.

"(iv) Ensuring that individuals receive a summary of care and medication orders upon discharge.

''(v) Developing a quality improvement plan to assess and remedy preventable readmission rates.

''(vi) Assigning discharged individuals to a medical home.

''(vii) Doing other activities as determined appropriate by the Secretary.

''(F) GAO REPORT ON USE OF FUNDS.—Not later than 3 years after the date on which funds are first made available under this paragraph, the Comptroller General of the United States shall submit to Congress a report on the use of such funds.

''(G) DISPROPORTIONATE SHARE HOSPITAL PAYMENT.—In this paragraph, the term 'disproportionate share hospital payment' means an additional payment amount under subsection (d)(5)(F).''.

(b) APPLICATION TO CRITICAL ACCESS HOSPITALS.—Section 1814(l) of the Social Security Act (42 U.S.C. 1395f(l)) is amended—

(1) in paragraph (5)—

(A) by striking ''and'' at the end of subparagraph (C);

(B) by striking the period at the end of subparagraph (D) and inserting ''; and'';

(C) by inserting at the end the following new subparagraph:

''(E) The methodology for determining the adjustment factor under paragraph (5), including the determination of aggregate payments for actual and expected readmissions, applicable periods, applicable conditions and measures of readmissions.''; and

(D) by redesignating such paragraph as paragraph (6); and

(2) by inserting after paragraph (4) the following new paragraph:

''(5) The adjustment factor described in section 1886(p)(3) shall apply to payments with respect to a critical access hospital with respect to a cost reporting period beginning in fiscal year 2012 and each subsequent fiscal year (after application of paragraph (4) of this subsection) in a manner similar to the manner in which such section applies with respect to a fiscal year to an applicable hospital as described in section 1886(p)(2).''.

(c) POST ACUTE CARE PROVIDERS.—

(1) INTERIM POLICY.—

(A) IN GENERAL.—With respect to a readmission to an applicable hospital or a critical

access hospital (as described in section 1814(l) of the Social Security Act) from a post acute care provider (as defined in paragraph (3)) and such a readmission is not governed by section 412.531 of title 42, Code of Federal Regulations, if the claim submitted by such a post-acute care provider under title XVIII of the Social Security Act indicates that the individual was readmitted to a hospital from such a post-acute care provider or admitted from home and under the care of a home health agency within 30 days of an initial discharge from an applicable hospital or critical access hospital, the payment under such title on such claim shall be the applicable percent specified in subparagraph (B) of the payment that would otherwise be made under the respective payment system under such title for such post-acute care provider if this subsection did not apply.

(B) APPLICABLE PERCENT DEFINED.—For purposes of subparagraph (A), the applicable percent is—

(i) for fiscal or rate year 2012 is 0.996;

(ii) for fiscal or rate year 2013 is 0.993; and

(iii) for fiscal or rate year 2014 is 0.99.

(C) EFFECTIVE DATE.—Subparagraph (1) shall apply to discharges or services furnished (as the case may be with respect to the applicable post acute care provider) on or after the first day of the fiscal year or rate year, beginning on or after October 1, 2011, with respect to the applicable post acute care provider.

(2) DEVELOPMENT AND APPLICATION OF PERFORMANCE MEASURES.—

(A) IN GENERAL.—The Secretary of Health and Human Services shall develop appropriate measures of readmission rates for post acute care providers. The Secretary shall seek endorsement of such measures by the entity with a contract under section 1890(a) of the Social Security Act but may adopt and apply such measures under this paragraph without such an endorsement. The Secretary shall expand such measures in a manner similar to the manner in which applicable conditions are expanded under paragraph (5)(B) of section

1886(p) of the Social Security Act, as added by subsection (a).

(B) IMPLEMENTATION.—The Secretary shall apply, on or after October 1, 2014, with respect to post acute care providers, policies similar to the policies applied with respect to applicable hospitals and critical access hospitals under the amendments made by subsection (a). The provisions of paragraph (1) shall apply with respect to any period on or after October 1, 2014, and before such application date described in the previous sentence in the same manner as such provisions apply with respect to fiscal or rate year 2014.

(C) MONITORING AND PENALTIES.—The provisions of paragraph (7) of such section 1886(p) shall apply to providers under this paragraph in the same manner as they apply to hospitals under such section.

(3) DEFINITIONS.—For purposes of this subsection:

(A) POST ACUTE CARE PROVIDER.—The term ''post acute care provider'' means—

(i) a skilled nursing facility (as defined in section 1819(a) of the Social Security Act);

(ii) an inpatient rehabilitation facility (described in section 1886(h)(1)(A) of such Act);

(iii) a home health agency (as defined in section 1861(o) of such Act); and

(iv) a long term care hospital (as defined in section 1861(ccc) of such Act).

(B) OTHER TERMS .—The terms ''applicable condition'', ''applicable hospital'', and ''readmission'' have the meanings given such terms in section 1886(p)(5) of the Social Security Act, as added by subsection (a)(1).

(d) PHYSICIANS.—

(1) STUDY.—The Secretary of Health and Human Services shall conduct a study to determine how the readmissions policy described in the previous subsections could be applied to physicians.

(2) CONSIDERATIONS.—In conducting the study, the Secretary shall consider approaches such as—

(A) creating a new code (or codes) and payment amount (or amounts) under the fee

schedule in section 1848 of the Social Security Act (in a budget neutral manner) for services furnished by an appropriate physician who sees an individual within the first week after discharge from a hospital or critical access hospital;

(B) developing measures of rates of readmission for individuals treated by physicians;

(C) applying a payment reduction for physicians who treat the patient during the initial admission that results in a readmission; and

(D) methods for attributing payments or payment reductions to the appropriate physician or physicians.

(3) REPORT.—The Secretary shall issue a public report on such study not later than the date that is one year after the date of the enactment of this Act.

(e) FUNDING.—For purposes of carrying out the provisions of this section, in addition to funds otherwise available, out of any funds in the Treasury not otherwise appropriated, there are appropriated to the Secretary of Health and Human Services for the Center for Medicare & Medicaid Services Program Management Account $25,000,000 for each fiscal year beginning with 2010.

Amounts appropriated under this subsection for a fiscal year shall be available until expended.

SEC. 1152. POST ACUTE CARE SERVICES PAYMENT REFORM PLAN AND BUNDLING PILOT PROGRAM.

(a) PLAN.—

(1) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall develop a detailed plan to reform payment for post acute care (PAC) services under the Medicare program under title XVIII of the Social Security Act (in this section referred to as the ''Medicare program)''. The goals of such payment reform are to—

(A) improve the coordination, quality, and efficiency of such services; and

(B) improve outcomes for individuals such as reducing the need for readmission to hospitals from providers of such services.

(2) BUNDLING POST ACUTE SERVICES.—The plan described in paragraph (1) shall include detailed specifications for a bundled payment for post acute services (in this section referred to as the ''post acute care bundle''), and may include other approaches determined appropriate by the Secretary.

(3) POST ACUTE SERVICES.—For purposes of this section, the term ''post acute services'' means services for which payment may be made under the Medicare program that are furnished by skilled nursing facilities, inpatient rehabilitation facilities, long term care hospitals, hospital based outpatient rehabilitation facilities and home health agencies to an individual after discharge of such individual from a hospital, and such other services determined appropriate by the Secretary.

(b) DETAILS.—The plan described in subsection (a)(1) shall include consideration of the following issues:

(1) The nature of payments under a post acute care bundle, including the type of provider or entity to whom payment should be made, the scope of activities and services included in the bundle, whether payment for physicians' services should be included in the bundle, and the period covered by the bundle.

(2) Whether the payment should be consolidated with the payment under the inpatient prospective system under section 1886 of the Social Security Act (in this section referred to as MS–DRGs) or a separate payment should be established for such bundle, and if a separate payment is established,

whether it should be made only upon use of post acute care services or for every discharge.

(3) Whether the bundle should be applied across all categories of providers of inpatient services (including critical access hospitals) and post acute care services or whether it should be limited to certain categories of providers, services, or discharges, such as high volume or high cost MS–DRGs.

(4) The extent to which payment rates could be established to achieve offsets for efficiencies that could be expected to be achieved with a bundle payment, whether such rates should be established on a national basis or for different geographic areas, should vary according to discharge, case mix, outliers, and geographic differences in wages or other appropriate adjustments, and how to update such rates.

(5) The nature of protections needed for individuals under a system of bundled payments to ensure that individuals receive quality care, are furnished the level and amount of services needed as determined by an appropriate assessment instrument, are offered choice of provider, and the extent to which transitional care services would improve

quality of care for individuals and the functioning of a bundled post-acute system.

(6) The nature of relationships that may be required between hospitals and providers of post acute care services to facilitate bundled payments, including the application of gainsharing, anti-referral, anti-kickback, and anti-trust laws.

(7) Quality measures that would be appropriate for reporting by hospitals and post acute providers (such as measures that assess changes in functional status and quality measures appropriate for each type of post acute services provider including how the reporting of such quality measures could be coordinated with other reporting of such quality measures by such providers otherwise required).

(8) How cost-sharing for a post acute care bundle should be treated relative to current rules for cost-sharing for inpatient hospital, home health, skilled nursing facility, and other services.

(9) How other programmatic issues should be treated in a post acute care bundle, including rules specific to various types of post-acute providers such as the post-acute transfer policy, three-day hospital stay to qualify for services furnished by skilled nursing facilities, and the coordination of payments and

care under the Medicare program and the Medicaid program.

(10) Such other issues as the Secretary deems appropriate.

(c) CONSULTATIONS AND ANALYSIS.—

(1) CONSULTATION WITH STAKEHOLDERS.—In developing the plan under subsection (a)(1), the Secretary shall consult with relevant stakeholders and shall consider experience with such research studies and demonstrations that the Secretary determines appropriate.

(2) ANALYSIS AND DATA COLLECTION.—In developing such plan, the Secretary shall—

(A) analyze the issues described in subsection (b) and other issues that the Secretary determines appropriate;

(B) analyze the impacts (including geographic impacts) of post acute service reform approaches, including bundling of such services on individuals, hospitals, post acute care providers, and physicians;

(C) use existing data (such as data submitted on claims) and collect such data as the Secretary determines are appropriate to develop such plan required in this section; and

(D) if patient functional status measures are appropriate for the analysis, to the extent practical, build upon the CARE tool being developed pursuant to section 5008 of the Deficit Reduction Act of 2005.

(d) ADMINISTRATION.—

(1) FUNDING.—For purposes of carrying out the provisions of this section, in addition to funds otherwise available, out of any funds in the Treasury not otherwise appropriated, there are appropriated to the Secretary for the Center for Medicare & Medicaid Services Program Management Account $15,000,000 for each of the fiscal years 2010 through 2012. Amounts appropriated under this paragraph for a fiscal year shall be available until expended.

(2) EXPEDITED DATA COLLECTION.—Chapter 35 of title 44, United States Code shall not apply to this section.

(e) PUBLIC REPORTS.—

(1) INTERIM REPORTS.—The Secretary shall issue interim public reports on a periodic basis on the plan described in subsection (a)(1), the issues described in subsection (b), and impact analyses as the Secretary determines appropriate.

(2) FINAL REPORT.—Not later than the date that is 3 years after the date of the enactment of this Act, the Secretary shall issue a final public report on such plan, including analysis of issues described in subsection (b) and impact analyses.

(f) CONVERSION OF ACUTE CARE EPISODE DEMONSTRATION TO PILOT PROGRAM AND EXPANSION TO INCLUDE POST ACUTE SERVICES.—

(1) IN GENERAL.—Part E of title XVIII of the Social Security Act is amended by inserting after section 1866C the following new section:

"**SEC. 1866D. CONVERSION OF ACUTE CARE EPISODE DEMONSTRATION TO PILOT PROGRAM AND EXPANSION TO INCLUDE POST ACUTE SERVICES.**

''(a) IN GENERAL.—By not later than January 1, 2011, the Secretary shall, for the purpose of promoting the use of bundled payments to promote efficient and high quality delivery of care—

''(1) convert the acute care episode demonstration program conducted under section 1866C to a pilot program; and

''(2) subject to subsection (c), expand such program as so converted to include post acute services and such other services the Secretary determines to

be appropriate, which may include transitional services.

''(b) SCOPE.—The pilot program under subsection (a) may include additional geographic areas and additional conditions which account for significant program spending, as defined by the Secretary. Nothing in this subsection shall be construed as limiting the number of hospital and physician groups or the number of hospital and post-acute provider groups that may participate in the pilot program.

''(c) LIMITATION.—The Secretary shall only expand the pilot program under subsection (a)(2) if the Secretary finds that—

''(1) the demonstration program under section 1866C and pilot program under this section maintain or increase the quality of care received by individuals enrolled under this title; and

''(2) such demonstration program and pilot program reduce program expenditures and, based on the certification under subsection (d), that the expansion of such pilot program would result in estimated spending that would be less than what spending would otherwise be in the absence of this section.

''(d) CERTIFICATION.—For purposes of subsection (c), the Chief Actuary of the Centers for Medicare & Med-

icaid Services shall certify whether expansion of the pilot program under this section would result in estimated spending that would be less than what spending would otherwise be in the absence of this section.

''(e) VOLUNTARY PARTICIPATION.—Nothing in this paragraph shall be construed as requiring the participation of an entity in the pilot program under this section.''.

(2) CONFORMING AMENDMENT.—Section 1866C(b) of the Social Security Act (42 U.S.C. 1395cc–3(b)) is amended by striking ''The Secretary'' and inserting ''Subject to section 1866D, the Secretary''.

SEC. 1153. HOME HEALTH PAYMENT UPDATE FOR 2010.

Section 1895(b)(3)(B)(ii) of the Social Security Act (42 U.S.C. 1395fff(b)(3)(B)(ii)) is amended—

(1) in subclause (IV), by striking ''and'';

(2) by redesignating subclause (V) as subclause (VII); and

(3) by inserting after subclause (IV) the following new subclauses:

''(V) 2007, 2008, and 2009, subject to clause (v), the home health market basket percentage increase;

''(VI) 2010, subject to clause (v), 0 percent; and''.

SEC. 1154. PAYMENT ADJUSTMENTS FOR HOME HEALTH CARE.

(a) ACCELERATION OF ADJUSTMENT FOR CASE MIX CHANGES.—Section 1895(b)(3)(B) of the Social Security Act (42 U.S.C. 1395fff(b)(3)(B)) is amended—

(1) in clause (iv), by striking ''Insofar as'' and inserting ''Subject to clause (vi), insofar as''; and

(2) by adding at the end the following new clause:

''(vi) SPECIAL RULE FOR CASE MIX CHANGES FOR 2011.—

''(I) IN GENERAL.—With respect to the case mix adjustments established in section 484.220(a) of title 42, Code of Federal Regulations, the Secretary shall apply, in 2010, the adjustment established in paragraph (3) of such section for 2011, in addition to applying the adjustment established in paragraph (2) for 2010.

''(II) CONSTRUCTION.—Nothing in this clause shall be construed as limiting the amount of adjustment for case mix for 2010 or 2011 if more recent data indicate an appropriate adjustment that is greater than the

amount established in the section described in subclause (I).''.

(b) REBASING HOME HEALTH PROSPECTIVE PAYMENT AMOUNT.—Section 1895(b)(3)(A) of the Social Security Act (42 U.S.C. 1395fff(b)(3)(A)) is amended—

(1) in clause (i)—

(A) in subclause (III), by inserting ''and before 2011'' after ''after the period described in subclause (II)''; and

(B) by inserting after subclause (III) the following new subclauses:

''(IV) Subject to clause (iii)(I), for 2011, such amount (or amounts) shall be adjusted by a uniform percentage determined to be appropriate by the Secretary based on analysis of factors such as changes in the average number and types of visits in an episode, the change in intensity of visits in an episode, growth in cost per episode, and other factors that the Secretary considers to be relevant.

''(V) Subject to clause (iii)(II), for a year after 2011, such a amount (or amounts) shall be equal to the

amount (or amounts) determined under this clause for the previous year, updated under subparagraph (B).''; and

(2) by adding at the end the following new clause:

''(iii) SPECIAL RULE IN CASE OF INABILITY TO EFFECT TIMELY REBASING.—

''(I) APPLICATION OF PROXY AMOUNT FOR 2011.—If the Secretary is not able to compute the amount (or amounts) under clause (i)(IV) so as to permit, on a timely basis, the application of such clause for 2011, the Secretary shall substitute for such amount (or amounts) 95 percent of the amount (or amounts) that would otherwise be specified under clause (i)(III) if it applied for 2011.

''(II) ADJUSTMENT FOR SUBSEQUENT YEARS BASED ON DATA.—If the Secretary applies subclause (I), the Secretary before July 1, 2011, shall compare the amount (or amounts) applied under such sub-

clause with the amount (or amounts) that should have been applied under clause (i)(IV). The Secretary shall decrease or increase the prospective payment amount (or amounts) under clause (i)(V) for 2012 (or, at the Secretary's discretion, over a period of several years beginning with 2012) by the amount (if any) by which the amount (or amounts) applied under subclause (I) is greater or less, respectively, than the amount (or amounts) that should have been applied under clause (i)(IV).''.

SEC. 1155. INCORPORATING PRODUCTIVITY IMPROVEMENTS INTO MARKET BASKET UPDATE FOR HOME HEALTH SERVICES.

(a) IN GENERAL.—Section 1895(b)(3)(B) of the Social Security Act (42 U.S.C. 1395fff(b)(3)(B)) is amended—

(1) in clause (iii), by inserting ''(including being subject to the productivity adjustment described in section 1886(b)(3)(B)(iii)(II))'' after ''in the same manner''; and

(2) in clause (v)(I), by inserting ''(but not below 0)'' after ''reduced''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to home health market basket percentage increases for years beginning with 2010.

SEC. 1156. LIMITATION ON MEDICARE EXCEPTIONS TO THE PROHIBITION ON CERTAIN PHYSICIAN REFERRALS MADE TO HOSPITALS.

(a) IN GENERAL.—Section 1877 of the Social Security Act (42 U.S.C. 1395nn) is amended—

(1) in subsection (d)(2)—

(A) in subparagraph (A), by striking ''and'' at the end;

(B) in subparagraph (B), by striking the period at the end and inserting ''; and''; and

(C) by adding at the end the following new subparagraph:

''(C) in the case where the entity is a hospital, the hospital meets the requirements of paragraph (3)(D).'';

(2) in subsection (d)(3)—

(A) in subparagraph (B), by striking ''and'' at the end;

(B) in subparagraph (C), by striking the period at the end and inserting ''; and''; and

(C) by adding at the end the following new subparagraph:

''(D) the hospital meets the requirements described in subsection (i)(1).'';

(3) by amending subsection (f) to read as follows:

''(f) REPORTING AND DISCLOSURE REQUIREMENTS.—

''(1) IN GENERAL.—Each entity providing covered items or services for which payment may be made under this title shall provide the Secretary with the information concerning the entity's ownership, investment, and compensation arrangements, including—

''(A) the covered items and services provided by the entity, and

''(B) the names and unique physician identification numbers of all physicians with an ownership or investment interest (as described in subsection (a)(2)(A)), or with a compensation arrangement (as described in subsection (a)(2)(B)), in the entity, or whose immediate relatives have such an ownership or investment interest or who have such a compensation relationship with the entity.

Such information shall be provided in such form, manner, and at such times as the Secretary shall specify. The requirement of this subsection shall not apply to designated health services provided outside the United States or to entities which the Secretary determines provide services for which payment may be made under this title very infrequently.

''(2) REQUIREMENTS FOR HOSPITALS WITH PHYSICIAN OWNERSHIP OR INVESTMENT.—In the case of a hospital that meets the requirements described in subsection (i)(1), the hospital shall—

''(A) submit to the Secretary an initial report, and periodic updates at a frequency determined by the Secretary, containing a detailed description of the identity of each physician owner and physician investor and any other owners or investors of the hospital;

''(B) require that any referring physician owner or investor discloses to the individual being referred, by a time that permits the individual to make a meaningful decision regarding the receipt of services, as determined by the Secretary, the ownership or investment interest, as applicable, of such referring physician in the hospital; and

''(C) disclose the fact that the hospital is partially or wholly owned by one or more physicians or has one or more physician investors—

''(i) on any public website for the hospital; and

''(ii) in any public advertising for the hospital.

The information to be reported or disclosed under this paragraph shall be provided in such form, manner, and at such times as the Secretary shall specify. The requirements of this paragraph shall not apply to designated health services furnished outside the United States or to entities which the Secretary determines provide services for which payment may be made under this title very infrequently.

''(3) PUBLICATION OF INFORMATION.—The Secretary shall publish, and periodically update, the information submitted by hospitals under paragraph (2)(A) on the public Internet website of the Centers for Medicare & Medicaid Services.'';

(4) by amending subsection (g)(5) to read as follows:

''(5) FAILURE TO REPORT OR DISCLOSE INFORMATION.—

''(A) REPORTING.—Any person who is required, but fails, to meet a reporting requirement of paragraphs (1) and (2)(A) of subsection (f) is subject to a civil money penalty of not more than $10,000 for each day for which reporting is required to have been made.

''(B) DISCLOSURE.—Any physician who is required, but fails, to meet a disclosure requirement of subsection (f)(2)(B) or a hospital that is required, but fails, to meet a disclosure requirement of subsection (f)(2)(C) is subject to a civil money penalty of not more than $10,000 for each case in which disclosure is required to have been made.

''(C) APPLICATION.—The provisions of section 1128A (other than the first sentence of subsection (a) and other than subsection (b)) shall apply to a civil money penalty under subparagraphs (A) and (B) in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).''; and

(5) by adding at the end the following new subsection:

''(i) REQUIREMENTS TO QUALIFY FOR RURAL PROVIDER AND HOSPITAL OWNERSHIP EXCEPTIONS TO SELF-REFERRAL PROHIBITION.—

''(1) REQUIREMENTS DESCRIBED.—For purposes of subsection (d)(3)(D), the requirements described in this paragraph are as follows:

''(A) PROVIDER AGREEMENT.—The hospital had—

''(i) physician ownership or investment on January 1, 2009; and

''(ii) a provider agreement under section 1866 in effect on such date.

''(B) PROHIBITION ON PHYSICIAN OWNERSHIP OR INVESTMENT.—The percentage of the total value of the ownership or investment interests held in the hospital, or in an entity whose assets include the hospital, by physician owners or investors in the aggregate does not exceed such percentage as of the date of enactment of this subsection.

''(C) PROHIBITION ON EXPANSION OF FACILITY CAPACITY.—Except as provided in paragraph (2), the number of operating rooms, procedure rooms, or beds of the hospital at any time on or after the date of the enactment of

this subsection are no greater than the number of operating rooms, procedure rooms, or beds, respectively, as of such date.

''(D) ENSURING BONA FIDE OWNERSHIP AND INVESTMENT.—

''(i) Any ownership or investment interests that the hospital offers to a physician are not offered on more favorable terms than the terms offered to a person who is not in a position to refer patients or otherwise generate business for the hospital.

''(ii) The hospital (or any investors in the hospital) does not directly or indirectly provide loans or financing for any physician owner or investor in the hospital.

''(iii) The hospital (or any investors in the hospital) does not directly or indirectly guarantee a loan, make a payment toward a loan, or otherwise subsidize a loan, for any physician owner or investor or group of physician owners or investors that is related to acquiring any ownership or investment interest in the hospital.

''(iv) Ownership or investment returns are distributed to each owner or investor in the hospital in an amount that is directly proportional to the ownership or investment interest of such owner or investor in the hospital.

''(v) The investment interest of the owner or investor is directly proportional to the owner's or investor's capital contributions made at the time the ownership or investment interest is obtained.

''(vi) Physician owners and investors do not receive, directly or indirectly, any guaranteed receipt of or right to purchase other business interests related to the hospital, including the purchase or lease of any property under the control of other owners or investors in the hospital or located near the premises of the hospital.

''(vii) The hospital does not offer a physician owner or investor the opportunity to purchase or lease any property under the control of the hospital or any other owner or investor in the hospital on more favorable terms than the terms of-

fered to a person that is not a physician owner or investor.

''(viii) The hospital does not condition any physician ownership or investment interests either directly or indirectly on the physician owner or investor making or influencing referrals to the hospital or otherwise generating business for the hospital.

''(E) PATIENT SAFETY.—In the case of a hospital that does not offer emergency services, the hospital has the capacity to—

''(i) provide assessment and initial treatment for medical emergencies; and

''(ii) if the hospital lacks additional capabilities required to treat the emergency involved, refer and transfer the patient with the medical emergency to a hospital with the required capability.

''(F) LIMITATION ON APPLICATION TO CERTAIN CONVERTED FACILITIES.—The hospital was not converted from an ambulatory surgical center to a hospital on or after the date of enactment of this subsection.

''(2) EXCEPTION TO PROHIBITION ON EXPANSION OF FACILITY CAPACITY.—

''(A) PROCESS.—

''(i) ESTABLISHMENT.—The Secretary shall establish and implement a process under which a hospital may apply for an exception from the requirement under paragraph (1)(C).

''(ii) OPPORTUNITY FOR COMMUNITY INPUT.—The process under clause (i) shall provide persons and entities in the community in which the hospital applying for an exception is located with the opportunity to provide input with respect to the application.

''(iii) TIMING FOR IMPLEMENTATION.—The Secretary shall implement the process under clause (i) on the date that is one month after the promulgation of regulations described in clause (iv).

''(iv) REGULATIONS.—Not later than the first day of the month beginning 18 months after the date of the enactment of this subsection, the Secretary shall promulgate regulations to carry out the process under clause (i). The Secretary may issue

such regulations as interim final regulations.

''(B) FREQUENCY.—The process described in subparagraph (A) shall permit a hospital to apply for an exception up to once every 2 years.

''(C) PERMITTED INCREASE.—

''(i) IN GENERAL.—Subject to clause (ii) and subparagraph (D), a hospital granted an exception under the process described in subparagraph (A) may increase the number of operating rooms, procedure rooms, or beds of the hospital above the baseline number of operating rooms, procedure rooms, or beds, respectively, of the hospital (or, if the hospital has been granted a previous exception under this paragraph, above the number of operating rooms, procedure rooms, or beds, respectively, of the hospital after the application of the most recent increase under such an exception).

''(ii) 100 PERCENT INCREASE LIMITATION.—The Secretary shall not permit an increase in the number of operating rooms, procedure rooms, or beds of a hospital

under clause (i) to the extent such increase would result in the number of operating rooms, procedure rooms, or beds of the hospital exceeding 200 percent of the baseline number of operating rooms, procedure rooms, or beds of the hospital.

''(iii) BASELINE NUMBER OF OPERATING ROOMS, PROCEDURE ROOMS, OR BEDS.—In this paragraph, the term 'baseline number of operating rooms, procedure rooms, or beds' means the number of operating rooms, procedure rooms, or beds of a hospital as of the date of enactment of this subsection.

''(D) INCREASE LIMITED TO FACILITIES ON THE MAIN CAMPUS OF THE HOSPITAL.—Any increase in the number of operating rooms, procedure rooms, or beds of a hospital pursuant to this paragraph may only occur in facilities on the main campus of the hospital.

''(E) CONDITIONS FOR APPROVAL OF AN INCREASE IN FACILITY CAPACITY.—The Secretary may grant an exception under the process described in subparagraph (A) only to a hospital—

''(i) that is located in a county in which the percentage increase in the population during the most recent 5-year period for which data are available is estimated to be at least 150 percent of the percentage increase in the population growth of the State in which the hospital is located during that period, as estimated by Bureau of the Census and available to the Secretary;

''(ii) whose annual percent of total inpatient admissions that represent inpatient admissions under the program under title XIX is estimated to be equal to or greater than the average percent with respect to such admissions for all hospitals located in the county in which the hospital is located;

''(iii) that does not discriminate against beneficiaries of Federal health care programs and does not permit physicians practicing at the hospital to discriminate against such beneficiaries;

''(iv) that is located in a State in which the average bed capacity in the State is estimated to be less than the national average bed capacity;

"(v) that has an average bed occupancy rate that is estimated to be greater than the average bed occupancy rate in the State in which the hospital is located; and

"(vi) that meets other conditions as determined by the Secretary.

"(F) PROCEDURE ROOMS.—In this subsection, the term 'procedure rooms' includes rooms in which catheterizations, angiographies, angiograms, and endoscopies are furnished, but such term shall not include emergency rooms or departments (except for rooms in which catheterizations, angiographies, angiograms, and endoscopies are furnished).

"(G) PUBLICATION OF FINAL DECISIONS.—Not later than 120 days after receiving a complete application under this paragraph, the Secretary shall publish on the public Internet website of the Centers for Medicare & Medicaid Services the final decision with respect to such application.

"(H) LIMITATION ON REVIEW.—There shall be no administrative or judicial review under section 1869, section 1878, or otherwise of the exception process under this paragraph,

including the establishment of such process, and any determination made under such process.

''(3) PHYSICIAN OWNER OR INVESTOR DEFINED.—For purposes of this subsection and subsection (f)(2), the term 'physician owner or investor' means a physician (or an immediate family member of such physician) with a direct or an indirect ownership or investment interest in the hospital.

''(4) PATIENT SAFETY REQUIREMENT.—In the case of a hospital to which the requirements of paragraph (1) apply, insofar as the hospital admits a patient and does not have any physician available on the premises 24 hours per day, 7 days per week, before admitting the patient—

''(A) the hospital shall disclose such fact to the patient; and

''(B) following such disclosure, the hospital shall receive from the patient a signed acknowledgment that the patient understands such fact.

''(5) CLARIFICATION.—Nothing in this subsection shall be construed as preventing the Secretary from terminating a hospital's provider agreement if the hospital is not in compliance with regulations pursuant to section 1866.''.

(b) VERIFYING COMPLIANCE.—The Secretary of Health and Human Services shall establish policies and procedures to verify compliance with the requirements described in subsections (i)(1) and (i)(4) of section 1877 of the Social Security Act, as added by subsection (a)(5). The Secretary may use unannounced site reviews of hospitals and audits to verify compliance with such requirements.

(c) IMPLEMENTATION.—

(1) FUNDING.—For purposes of carrying out the amendments made by subsection (a) and the provisions of subsection (b), in addition to funds otherwise available, out of any funds in the Treasury not otherwise appropriated there are appropriated to the Secretary of Health and Human Services for the Centers for Medicare & Medicaid Services Program Management Account $5,000,000 for each fiscal year beginning with fiscal year 2010. Amounts appropriated under this paragraph for a fiscal year shall be available until expended.

(2) ADMINISTRATION.—Chapter 35 of title 44, United States Code, shall not apply to the amendments made by subsection (a) and the provisions of subsection (b).

SEC. 1157. INSTITUTE OF MEDICINE STUDY OF GEOGRAPHIC ADJUSTMENT FACTORS UNDER MEDICARE.

(a) IN GENERAL.—The Secretary of Health and Human Services shall enter into a contract with the Institute of Medicine of the National Academy of Science to conduct a comprehensive empirical study, and provide recommendations as appropriate, on the accuracy of the geographic adjustment factors established under sections 1848(e) and 1886(d)(3)(E) of the Social Security Act (42 U.S.C. 1395w–4(e), 11395ww(d)(3)).

(b) MATTERS INCLUDED.—Such study shall include an evaluation and assessment of the following with respect to such adjustment factors:

(1) Empirical validity of the adjustment factors.

(2) Methodology used to determine the adjustment factors.

(3) Measures used for the adjustment factors, taking into account—

(A) timeliness of data and frequency of revisions to such data;

(B) sources of data and the degree to which such data are representative of costs; and

(C) operational costs of providers who participate in Medicare.

(c) EVALUATION.—Such study shall, within the context of the United States health care marketplace, evaluate and consider the following:

(1) The effect of the adjustment factors on the level and distribution of the health care workforce and resources, including—

(A) recruitment and retention that takes into account workforce mobility between urban and rural areas;

(B) ability of hospitals and other facilities to maintain an adequate and skilled workforce; and

(C) patient access to providers and needed medical technologies.

(2) The effect of the adjustment factors on population health and quality of care.

(3) The effect of the adjustment factors on the ability of providers to furnish efficient, high value care.

(d) REPORT.—The contract under subsection (a) shall provide for the Institute of Medicine to submit, not later than one year after the date of the enactment of this Act, to the Secretary and the Congress a report containing results and recommendations of the study conducted under this section.

(e) FUNDING.—There are authorized to be appropriated to carry out this section such sums as may be necessary.

SEC. 1158. REVISION OF MEDICARE PAYMENT SYSTEMS TO ADDRESS GEOGRAPHIC INEQUITIES.

(a) IN GENERAL.—The Secretary of Health and Human Services, taking into account the recommendations made in the report under section 1157(d), shall include in the proposed rules published to implement changes to payment systems for physicians and hospitals under sections 1848(e) and 1886(d)(3)(E), respectively, of the Social Security Act, proposals to revise geographic adjustment factors for such payment systems for services furnished under the Medicare program. Such proposed rules shall be published in the rulemaking period immediately following submission of the report under section 1157(d).

(b) PAYMENT ADJUSTMENTS.—

(1) FUNDING FOR IMPROVEMENTS.—In making any changes to the geographic adjustment factors in accordance with subsection (a), the Secretary shall use funds made available for such purposes under subsection (c).

(2) ENSURING FAIRNESS.—In carrying out this subsection, the Secretary shall not change payment

rates to be less than they would have been had this section not been enacted.

(c) FUNDING.—Amounts in the Medicare Improvement Fund under section 1898 of the Social Security Act (42 U.S.C. 1395iii), as amended by section 1146, shall be available to the Secretary to make changes to the geographic adjustments factors established under sections 1848(e) and 1886(d)(3)(E) of the Social Security Act. For such purpose, such funds shall be available for expenditure for services furnished before January 1, 2014, and shall not exceed the total amounts available under such Fund for such period. No more than one-half of such amounts shall be available for expenditure for services furnished in any one payment year.

Subtitle D—Medicare Advantage Reforms

PART 1—PAYMENT AND ADMINISTRATION

SEC. 1161. PHASE-IN OF PAYMENT BASED ON FEE-FOR-SERVICE COSTS.

Section 1853 of the Social Security Act (42 U.S.C. 1395w–23) is amended—

(1) in subsection (j)(1)(A)—

(A) by striking ''beginning with 2007'' and inserting ''for 2007, 2008, 2009, and 2010''; and

(B) by inserting after ''(k)(1)'' the following: '', or, beginning with 2011, 1/12 of the blended benchmark amount determined under subsection (n)(1)''; and

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

''(n) DETERMINATION OF BLENDED BENCHMARK AMOUNT.—

''(1) IN GENERAL.—For purposes of subsection (j), subject to paragraphs (3) and (4), the term 'blended benchmark amount' means for an area—

''(A) for 2011 the sum of—

''(i) 2/3 of the applicable amount (as defined in subsection (k)) for the area and year; and

''(ii) 1/3 of the amount specified in paragraph (2) for the area and year;

''(B) for 2012 the sum of—

''(i) 1/3 of the applicable amount for the area and year; and

''(ii) 2/3 of the amount specified in paragraph (2) for the area and year; and

''(C) for a subsequent year the amount specified in paragraph (2) for the area and year.

''(2) SPECIFIED AMOUNT.—The amount specified in this paragraph for an area and year is the amount specified in subsection (c)(1)(D)(i) for the area and year adjusted (in a manner specified by the Secretary) to take into account the phase-out in the indirect costs of medical education from capitation rates described in subsection (k)(4).

''(3) FEE-FOR-SERVICE PAYMENT FLOOR.—In no case shall the blended benchmark amount for an area and year be less than the amount specified in paragraph (2).

''(4) EXCEPTION FOR PACE PLANS.—This subsection shall not apply to payments to a PACE program under section 1894.''.

SEC. 1162. QUALITY BONUS PAYMENTS.

(a) IN GENERAL.—Section 1853 of the Social Security Act (42 U.S.C. 1395w-23), as amended by section 1161, is amended—

(1) in subsection (j), by inserting ''subject to subsection (o),'' after ''For purposes of this part''; and

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

''(o) QUALITY BASED PAYMENT ADJUSTMENT.—

''(1) HIGH QUALITY PLAN ADJUSTMENT.—For years beginning with 2011, in the case of a Medicare Advantage plan that is identified (under paragraph (3)(E)(ii)) as a high quality MA plan with respect to the year, the blended benchmark amount under subsection (n)(1) shall be increased—

''(A) for 2011, by 1.0 percent;

''(B) for 2012, by 2.0 percent; and

''(C) for a subsequent year, by 3.0 percent.

''(2) IMPROVED QUALITY PLAN ADJUSTMENT.—For years beginning with 2011, in the case of a Medicare Advantage plan that is identified (under paragraph (3)(E)(iii)) as an improved quality MA plan with respect to the year, blended benchmark amount under subsection (n)(1) shall be increased—

''(A) for 2011, by 0.33 percent;

''(B) for 2012, by 0.66 percent; and

''(C) for a subsequent year, by 1.0 percent.

''(3) DETERMINATIONS OF QUALITY.—

''(A) QUALITY PERFORMANCE.—The Secretary shall provide for the computation of a quality performance score for each Medicare Advantage plan to be applied for each year beginning with 2010.

''(B) COMPUTATION OF SCORE.—

''(i) FOR YEARS BEFORE 2014.—For years before 2014, the quality performance score for a Medicare Advantage plan shall be computed based on a blend (as designated by the Secretary) of the plan's performance on—

''(I) HEDIS effectiveness of care quality measures;

''(II) CAHPS quality measures; and

''(III) such other measures of clinical quality as the Secretary may specify.

Such measures shall be risk-adjusted as the Secretary deems appropriate.

''(ii) ESTABLISHMENT OF OUTCOME-BASED MEASURES.—By not later than for 2013 the Secretary shall implement reporting requirements for quality under this section on measures selected under clause (iii) that reflect the outcomes of care experienced by individuals enrolled in Medicare Advantage plans (in addition to measures described in clause (i)). Such measures may include—

"(I) measures of rates of admission and readmission to a hospital;

"(II) measures of prevention quality, such as those established by the Agency for Healthcare Research and Quality (that include hospital admission rates for specified conditions);

"(III) measures of patient mortality and morbidity following surgery;

"(IV) measures of health functioning (such as limitations on activities of daily living) and survival for patients with chronic diseases;

"(V) measures of patient safety; and

"(VI) other measure of outcomes and patient quality of life as determined by the Secretary.

Such measures shall be risk-adjusted as the Secretary deems appropriate. In determining the quality measures to be used under this clause, the Secretary shall take into consideration the recommendations of the Medicare Payment Advisory Commission in its report to Congress under section

168 of the Medicare Improvements for Patients and Providers Act of 2008 (Public Law 110–275) and shall provide preference to measures collected on and comparable to measures used in measuring quality under parts A and B.

''(iii) RULES FOR SELECTION OF MEASURES.—The Secretary shall select measures for purposes of clause (ii) consistent with the following:

''(I) The Secretary shall provide preference to clinical quality measures that have been endorsed by the entity with a contract with the Secretary under section 1890(a).

''(II) Prior to any measure being selected under this clause, the Secretary shall publish in the Federal Register such measure and provide for a period of public comment on such measure.

''(iv) TRANSITIONAL USE OF BLEND.—For payments for 2014 and 2015, the Secretary may compute the quality performance score for a Medicare Ad-

vantage plan based on a blend of the measures specified in clause (i) and the measures described in clause (ii) and selected under clause (iii).

''(v) USE OF QUALITY OUTCOMES MEASURES.—For payments beginning with 2016, the preponderance of measures used under this paragraph shall be quality outcomes measures described in clause (ii) and selected under clause (iii).

''(C) DATA USED IN COMPUTING SCORE.—Such score for application for—

''(i) payments in 2011 shall be based on quality performance data for plans for 2009; and

''(ii) payments in 2012 and a subsequent year shall be based on quality performance data for plans for the second preceding year.

''(D) REPORTING OF DATA.—Each Medicare Advantage organization shall provide for the reporting to the Secretary of quality performance data described in subparagraph (B) (in order to determine a quality performance

score under this paragraph) in such time and manner as the Secretary shall specify.

''(E) RANKING OF PLANS.—

''(i) INITIAL RANKING.—Based on the quality performance score described in subparagraph (B) achieved with respect to a year, the Secretary shall rank plan performance—

''(I) from highest to lowest based on absolute scores; and

''(II) from highest to lowest based on percentage improvement in the score for the plan from the previous year.

A plan which does not report quality performance data under subparagraph (D) shall be counted, for purposes of such ranking, as having the lowest plan performance and lowest percentage improvement.

''(ii) IDENTIFICATION OF HIGH QUALITY PLANS IN TOP QUINTILE BASED ON PROJECTED ENROLLMENT.—The Secretary shall, based on the scores for each plan under clause (i)(I) and the Secretary's pro-

jected enrollment for each plan and subject to clause (iv), identify those Medicare Advantage plans with the highest score that, based upon projected enrollment, are projected to include in the aggregate 20 percent of the total projected enrollment for the year. For purposes of this subsection, a plan so identified shall be referred to in this subsection as a 'high quality MA plan'.

''(iii) IDENTIFICATION OF IMPROVED QUALITY PLANS IN TOP QUINTILE BASED ON PROJECTED ENROLLMENT.—The Secretary shall, based on the percentage improvement score for each plan under clause (i)(II) and the Secretary's projected enrollment for each plan and subject to clause (iv), identify those Medicare Advantage plans with the greatest percentage improvement score that, based upon projected enrollment, are projected to include in the aggregate 20 percent of the total projected enrollment for the year. For purposes of this subsection, a plan so identified that is not a high quality plan for the year shall

be referred to in this subsection as an 'improved quality MA plan'.

''(iv) AUTHORITY TO DISQUALIFY CERTAIN PLANS.—In applying clauses (ii) and (iii), the Secretary may determine not to identify a Medicare Advantage plan if the Secretary has identified deficiencies in the plan's compliance with rules for such plans under this part.

''(F) NOTIFICATION.—The Secretary, in the annual announcement required under subsection (b)(1)(B) in 2011 and each succeeding year, shall notify the Medicare Advantage organization that is offering a high quality plan or an improved quality plan of such identification for the year and the quality performance payment adjustment for such plan for the year. The Secretary shall provide for publication on the website for the Medicare program of the information described in the previous sentence.''.

SEC. 1163. EXTENSION OF SECRETARIAL CODING INTENSITY ADJUSTMENT AUTHORITY.

Section 1853(a)(1)(C)(ii) of the Social Security Act (42 U.S.C. 1395w–23(a)(1)(C)(ii) is amended—

(1) in the matter before subclause (I), by striking ''through 2010'' and inserting ''and each subsequent year''; and

(2) in subclause (II)—

(A) by inserting ''periodically'' before ''conduct an analysis'';

(B) by inserting ''on a timely basis'' after ''are incorporated''; and

(C) by striking ''only for 2008, 2009, and 2010'' and inserting ''for 2008 and subsequent years''.

SEC. 1164. SIMPLIFICATION OF ANNUAL BENEFICIARY ELECTION PERIODS.

(a) 2 WEEK PROCESSING PERIOD FOR ANNUAL ENROLLMENT PERIOD (AEP).—Paragraph (3)(B) of section 1851(e) of the Social Security Act (42 U.S.C. 1395w–21(e)) is amended—

(1) by striking ''and'' at the end of clause (iii);

(2) in clause (iv)—

(A) by striking ''and succeeding years'' and inserting '', 2008, 2009, and 2010''; and

(B) by striking the period at the end and inserting ''; and''; and

(3) by adding at the end the following new clause:

''(v) with respect to 2011 and succeeding years, the period beginning on November 1 and ending on December 15 of the year before such year.''.

(b) ELIMINATION OF 3-MONTH ADDITIONAL OPEN ENROLLMENT PERIOD (OEP).—Effective for plan years beginning with 2011, paragraph (2) of such section is amended by striking subparagraph (C).

SEC. 1165. EXTENSION OF REASONABLE COST CONTRACTS.

Section 1876(h)(5)(C) of the Social Security Act (42 U.S.C. 1395mm(h)(5)(C)) is amended—

(1) in clause (ii), by striking ''January 1, 2010'' and inserting ''January 1, 2012''; and

(2) in clause (iii), by striking ''the service area for the year'' and inserting ''the portion of the plan's service area for the year that is within the service area of a reasonable cost reimbursement contract''.

SEC. 1166. LIMITATION OF WAIVER AUTHORITY FOR EMPLOYER GROUP PLANS.

(a) IN GENERAL.—The first sentence of paragraph (2) of section 1857(i) of the Social Security Act (42 U.S.C. 1395w–27(i)) is amended by inserting before the period at the end the following: '', but only if 90 percent of the Medicare Advantage eligible individuals enrolled

under such plan reside in a county in which the MA organization offers an MA local plan''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply for plan years beginning on or after January 1, 2011, and shall not apply to plans which were in effect as of December 31, 2010.

SEC. 1167. IMPROVING RISK ADJUSTMENT FOR PAYMENTS.

(a) REPORT TO CONGRESS.—Not later than 1 year after the date of the enactment of this Act, the Secretary of Health and Human Services shall submit to Congress a report that evaluates the adequacy of the risk adjustment system under section 1853(a)(1)(C) of the Social Security Act (42 U.S.C. 1395–23(a)(1)(C)) in predicting costs for beneficiaries with chronic or co-morbid conditions, beneficiaries dually-eligible for Medicare and Medicaid, and non-Medicaid eligible low-income beneficiaries; and the need and feasibility of including further gradations of diseases or conditions and multiple years of beneficiary data.

(b) IMPROVEMENTS TO RISK ADJUSTMENT.—Not later than January 1, 2012, the Secretary shall implement necessary improvements to the risk adjustment system under section 1853(a)(1)(C) of the Social Security Act (42 U.S.C. 1395–23(a)(1)(C)), taking into account the evaluation under subsection (a).

SEC. 1168. ELIMINATION OF MA REGIONAL PLAN STABILIZATION FUND.

(a) IN GENERAL.—Section 1858 of the Social Security Act (42 U.S.C. 1395w–27a) is amended by striking subsection (e).

(b) TRANSITION.—Any amount contained in the MA Regional Plan Stabilization Fund as of the date of the enactment of this Act shall be transferred to the Federal Supplementary Medical Insurance Trust Fund.

PART 2—BENEFICIARY PROTECTIONS AND ANTI-FRAUD

SEC. 1171. LIMITATION ON COST-SHARING FOR INDIVIDUAL HEALTH SERVICES.

(a) IN GENERAL.—Section 1852(a)(1) of the Social Security Act (42 U.S.C. 1395w–22(a)(1)) is amended—

(1) in subparagraph (A), by inserting before the period at the end the following: ''with cost-sharing that is no greater (and may be less) than the cost-sharing that would otherwise be imposed under such program option'';

(2) in subparagraph (B)(i), by striking ''or an actuarially equivalent level of cost-sharing as determined in this part''; and

(3) by amending clause (ii) of subparagraph (B) to read as follows:

''(ii) PERMITTING USE OF FLAT COPAYMENT OR PER DIEM RATE.—Nothing in clause (i) shall be construed as prohibiting a Medicare Advantage plan from using a flat copayment or per diem rate, in lieu of the cost-sharing that would be imposed under part A or B, so long as the amount of the cost-sharing imposed does not exceed the amount of the cost-sharing that would be imposed under the respective part if the individual were not enrolled in a plan under this part.''.

(b) LIMITATION FOR DUAL ELIGIBLES AND QUALIFIED MEDICARE BENEFICIARIES.—Section 1852(a) of such Act is amended by adding at the end the following new paragraph:

''(7) LIMITATION ON COST-SHARING FOR DUAL ELIGIBLES AND QUALIFIED MEDICARE BENEFICIARIES.—In the case of a individual who is a full-benefit dual eligible individual (as defined in section 1935(c)(6)) or a qualified medicare beneficiary (as defined in section 1905(p)(1)) who is enrolled in a Medicare Advantage plan, the plan may not impose cost-sharing that exceeds the amount of cost-sharing that would be permitted with respect to the indi-

vidual under this title and title XIX if the individual were not enrolled with such plan.''.

(c) EFFECTIVE DATES.—

(1) The amendments made by subsection (a) shall apply to plan years beginning on or after January 1, 2011.

(2) The amendments made by subsection (b) shall apply to plan years beginning on or after January 1, 2011.

SEC. 1172. CONTINUOUS OPEN ENROLLMENT FOR ENROLLEES IN PLANS WITH ENROLLMENT SUSPENSION.

Section 1851(e)(4) of the Social Security Act (42 U.S.C. 1395w(e)(4)) is amended—

(1) in subparagraph (C), by striking at the end ''or'';

(2) in subparagraph (D)—

(A) by inserting '', taking into account the health or well-being of the individual'' before the period; and

(B) by redesignating such subparagraph as subparagraph (E); and

(3) by inserting after subparagraph (C) the following new subparagraph:

''(D)) the individual is enrolled in an MA plan and enrollment in the plan is suspended under paragraph (2)(B) or (3)(C) of section 1857(g) because of a failure of the plan to meet applicable requirements; or''.

SEC. 1173. INFORMATION FOR BENEFICIARIES ON MA PLAN ADMINISTRATIVE COSTS.

(a) DISCLOSURE OF MEDICAL LOSS RATIOS AND OTHER EXPENSE DATA.—Section 1851 of the Social Security Act (42 U.S.C. 1395w–21), as previously amended by this subtitle, is amended by adding at the end the following new subsection:

''(p) PUBLICATION OF MEDICAL LOSS RATIOS AND OTHER COST-RELATED INFORMATION.—

''(1) IN GENERAL.—The Secretary shall publish, not later than November 1 of each year (beginning with 2011), for each MA plan contract, the medical loss ratio of the plan in the previous year.

''(2) SUBMISSION OF DATA.—

''(A) IN GENERAL.—Each MA organization shall submit to the Secretary, in a form and manner specified by the Secretary, data necessary for the Secretary to publish the medical loss ratio on a timely basis.

''(B) DATA FOR 2010 AND 2011.—The data submitted under subparagraph (A) for 2010 and for 2011 shall be consistent in content with the data reported as part of the MA plan bid in June 2009 for 2010.

''(C) USE OF STANDARDIZED ELEMENTS AND DEFINITIONS.—The data to be submitted under subparagraph (A) relating to medical loss ratio for a year, beginning with 2012, shall be submitted based on the standardized elements and definitions developed under paragraph (3).

''(3) DEVELOPMENT OF DATA REPORTING STANDARDS.—

''(A) IN GENERAL.—The Secretary shall develop and implement standardized data elements and definitions for reporting under this subsection, for contract years beginning with 2012, of data necessary for the calculation of the medical loss ratio for MA plans. Not later than December 31, 2010, the Secretary shall publish a report describing the elements and definitions so developed.

''(B) CONSULTATION.—The Secretary shall consult with the Health Choices Commissioner, representatives of MA organizations, ex-

perts on health plan accounting systems, and representatives of the National Association of Insurance Commissioners, in the development of such data elements and definitions.

''(4) MEDICAL LOSS RATIO TO BE DEFINED.—For purposes of this part, the term 'medical loss ratio' has the meaning given such term by the Secretary, taking into account the meaning given such term by the Health Choices Commissioner under section 116 of the America's Affordable Health Choices Act of 2009.''.

(b) MINIMUM MEDICAL LOSS RATIO.—Section 1857(e) of the Social Security Act (42 U.S.C. 1395w–27(e)) is amended by adding at the end the following new paragraph:

''(4) REQUIREMENT FOR MINIMUM MEDICAL LOSS RATIO.—If the Secretary determines for a contract year (beginning with 2014) that an MA plan has failed to have a medical loss ratio (as defined in section 1851(p)(4)) of at least .85—

''(A) the Secretary shall require the Medicare Advantage organization offering the plan to give enrollees a rebate (in the second succeeding contract year) of premiums under this part (or part B or part D, if applicable) by

such amount as would provide for a benefits ratio of at least .85;

''(B) for 3 consecutive contract years, the Secretary shall not permit the enrollment of new enrollees under the plan for coverage during the second succeeding contract year; and

''(C) the Secretary shall terminate the plan contract if the plan fails to have such a medical loss ratio for 5 consecutive contract years.''.

SEC. 1174. STRENGTHENING AUDIT AUTHORITY.

(a) FOR PART C PAYMENTS RISK ADJUSTMENT.—Section 1857(d)(1) of the Social Security Act (42 U.S.C. 1395w–27(d)(1)) is amended by inserting after ''section 1858(c))'' the following: '', and data submitted with respect to risk adjustment under section 1853(a)(3)''.

(b) ENFORCEMENT OF AUDITS AND DEFICIENCIES.—

(1) IN GENERAL.—Section 1857(e) of such Act, as amended by section 1173, is amended by adding at the end the following new paragraph:

''(5) ENFORCEMENT OF AUDITS AND DEFICIENCIES.—

''(A) INFORMATION IN CONTRACT.—The Secretary shall require that each contract with an MA organization under this section shall in-

clude terms that inform the organization of the provisions in subsection (d).

''(B) ENFORCEMENT AUTHORITY.—The Secretary is authorized, in connection with conducting audits and other activities under subsection (d), to take such actions, including pursuit of financial recoveries, necessary to address deficiencies identified in such audits or other activities.''.

(2) APPLICATION UNDER PART D.—For provision applying the amendment made by paragraph (1) to prescription drug plans under part D, see section 1860D–12(b)(3)(D) of the Social Security Act.

(c) EFFECTIVE DATE.—The amendments made by this section shall take effect on the date of the enactment of this Act and shall apply to audits and activities conducted for contract years beginning on or after January 1, 2011.

SEC. 1175. AUTHORITY TO DENY PLAN BIDS.

(a) IN GENERAL.—Section 1854(a)(5) of the Social Security Act (42 U.S.C. 1395w–24(a)(5)) is amended by adding at the end the following new subparagraph:

''(C) REJECTION OF BIDS.—Nothing in this section shall be construed as requiring the

Secretary to accept any or every bid by an MA organization under this subsection.''.

(b) APPLICATION UNDER PART D.—Section 1860D–11(d) of such Act (42 U.S.C. 1395w–111(d)) is amended by adding at the end the following new paragraph:

''(3) REJECTION OF BIDS.—Paragraph (5)(C) of section 1854(a) shall apply with respect to bids under this section in the same manner as it applies to bids by an MA organization under such section.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to bids for contract years beginning on or after January 1, 2011.

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.

Section 1859(f)(4) of the Social Security Act (42 U.S.C. 1395w–28(f)(4)) is amended by adding at the end the following new subparagraph:

''(C) The plan does not enroll an individual on or after January 1, 2011, other than during an annual, coordinated open enrollment period or when at the time of the diagnosis of the disease or condition that qualifies the individual as

an individual described in subsection (b)(6)(B)(iii).''.

SEC. 1177. EXTENSION OF AUTHORITY OF SPECIAL NEEDS PLANS TO RESTRICT ENROLLMENT.

(a) IN GENERAL.—Section 1859(f)(1) of the Social Security Act (42 U.S.C. 1395w–28(f)(1)) is amended by striking ''January 1, 2011'' and inserting ''January 1, 2013 (or January 1, 2016, in the case of a plan described in section 1177(b)(1) of the America's Affordable Health Choices Act of 2009)''.

(b) GRANDFATHERING OF CERTAIN PLANS.—

(1) PLANS DESCRIBED.—For purposes of section 1859(f)(1) of the Social Security Act (42 U.S.C. 1395w–28(f)(1)), a plan described in this paragraph is a plan that had a contract with a State that had a State program to operate an integrated Medicaid-Medicare program that had been approved by the Centers for Medicare & Medicaid Services as of January 1, 2004.

(2) ANALYSIS; REPORT.—The Secretary of Health and Human Services shall provide, through a contract with an independent health services evaluation organization, for an analysis of the plans described in paragraph (1) with regard to the impact of such plans on cost, quality of care, patient satis-

faction, and other subjects as specified by the Secretary. Not later than December 31, 2011, the Secretary shall submit to Congress a report on such analysis and shall include in such report such recommendations with regard to the treatment of such plans as the Secretary deems appropriate.

Subtitle E—Improvements to Medicare Part D

SEC. 1181. ELIMINATION OF COVERAGE GAP.

(a) IN GENERAL.—Section 1860D–2(b) of such Act (42 U.S.C. 1395w–102(b)) is amended—

(1) in paragraph (3)(A), by striking ''paragraph (4)'' and inserting ''paragraphs (4) and (7)'';

(2) in paragraph (4)(B)(i), by inserting ''subject to paragraph (7)'' after ''purposes of this part''; and

(3) by adding at the end the following new paragraph:

''(7) PHASED-IN ELIMINATION OF COVERAGE GAP.—

''(A) IN GENERAL.—For each year beginning with 2011, the Secretary shall consistent with this paragraph progressively increase the initial coverage limit (described in subsection (b)(3)) and decrease the annual out-of-pocket

threshold from the amounts otherwise computed until there is a continuation of coverage from the initial coverage limit for expenditures incurred through the total amount of expenditures at which benefits are available under paragraph (4).

''(B) INCREASE IN INITIAL COVERAGE LIMIT.—For a year beginning with 2011, the initial coverage limit otherwise computed without regard to this paragraph shall be increased by ½ of the cumulative phase-in percentage (as defined in subparagraph (D)(ii) for the year) times the out-of-pocket gap amount (as defined in subparagraph (E)) for the year.

''(C) DECREASE IN ANNUAL OUT-OF-POCKET THRESHOLD.—For a year beginning with 2011, the annual out-of-pocket threshold otherwise computed without regard to this paragraph shall be decreased by ½ of the cumulative phase-in percentage of the out-of-pocket gap amount for the year multiplied by 1.75.

''(D) PHASE–IN.—For purposes of this paragraph:

"(i) ANNUAL PHASE-IN PERCENTAGE.—The term 'annual phase-in percentage' means—

"(I) for 2011, 13 percent;

"(II) for 2012, 2013, 2014, and 2015, 5 percent;

"(III) for 2016 through 2018, 7.5 percent; and

"(IV) for 2019 and each subsequent year, 10 percent.

"(ii) CUMULATIVE PHASE-IN PERCENTAGE.—The term 'cumulative phase-in percentage' means for a year the sum of the annual phase-in percentage for the year and the annual phase-in percentages for each previous year beginning with 2011, but in no case more than 100 percent.

"(E) OUT-OF-POCKET GAP AMOUNT.—For purposes of this paragraph, the term 'out-of-pocket gap amount' means for a year the amount by which—

"(i) the annual out-of-pocket threshold specified in paragraph (4)(B) for the

year (as determined as if this paragraph did not apply), exceeds

''(ii) the sum of—

''(I) the annual deductible under paragraph (1) for the year; and

''(II) ¼ of the amount by which the initial coverage limit under paragraph (3) for the year (as determined as if this paragraph did not apply) exceeds such annual deductible.''.

(b) REQUIRING DRUG MANUFACTURERS TO PROVIDE DRUG REBATES FOR FULL-BENEFIT DUAL ELIGIBLES.—

(1) IN GENERAL.—Section 1860D–2 of the Social Security Act (42 U.S.C. 1396r–8) is amended—

(A) in subsection (e)(1), in the matter before subparagraph (A), by inserting ''and subsection (f)'' after ''this subsection''; and

(B) by adding at the end the following new subsection:

''(f) PRESCRIPTION DRUG REBATE AGREEMENT FOR FULL-BENEFIT DUAL ELIGIBLE INDIVIDUALS.—

''(1) IN GENERAL.—In this part, the term 'covered part D drug' does not include any drug or biologic that is manufactured by a manufacturer that

has not entered into and have in effect a rebate agreement described in paragraph (2).

''(2) REBATE AGREEMENT.—A rebate agreement under this subsection shall require the manufacturer to provide to the Secretary a rebate for each rebate period (as defined in paragraph (6)(B)) ending after December 31, 2010, in the amount specified in paragraph (3) for any covered part D drug of the manufacturer dispensed after December 31, 2010, to any full-benefit dual eligible individual (as defined in paragraph (6)(A)) for which payment was made by a PDP sponsor under part D or a MA organization under part C for such period. Such rebate shall be paid by the manufacturer to the Secretary not later than 30 days after the date of receipt of the information described in section 1860D–12(b)(7), including as such section is applied under section 1857(f)(3).

''(3) REBATE FOR FULL-BENEFIT DUAL ELIGIBLE MEDICARE DRUG PLAN ENROLLEES.—

''(A) IN GENERAL.—The amount of the rebate specified under this paragraph for a manufacturer for a rebate period, with respect to each dosage form and strength of any covered part D drug provided by such manufacturer

and dispensed to a full-benefit dual eligible individual, shall be equal to the product of—

''(i) the total number of units of such dosage form and strength of the drug so provided and dispensed for which payment was made by a PDP sponsor under part D or a MA organization under part C for the rebate period (as reported under section 1860D–12(b)(7), including as such section is applied under section 1857(f)(3)); and

''(ii) the amount (if any) by which—

''(I) the Medicaid rebate amount (as defined in subparagraph (B)) for such form, strength, and period, exceeds

''(II) the average Medicare drug program full-benefit dual eligible rebate amount (as defined in subparagraph (C)) for such form, strength, and period.

''(B) MEDICAID REBATE AMOUNT.—For purposes of this paragraph, the term 'Medicaid rebate amount' means, with respect to each dosage form and strength of a covered part D

drug provided by the manufacturer for a rebate period—

''(i) in the case of a single source drug or an innovator multiple source drug, the amount specified in paragraph (1)(A)(ii) of section 1927(b) plus the amount, if any, specified in paragraph (2)(A)(ii) of such section, for such form, strength, and period; or

''(ii) in the case of any other covered outpatient drug, the amount specified in paragraph (3)(A)(i) of such section for such form, strength, and period.

''(C) AVERAGE MEDICARE DRUG PROGRAM FULL-BENEFIT DUAL ELIGIBLE REBATE AMOUNT.—For purposes of this subsection, the term 'average Medicare drug program full-benefit dual eligible rebate amount' means, with respect to each dosage form and strength of a covered part D drug provided by a manufacturer for a rebate period, the sum, for all PDP sponsors under part D and MA organizations administering a MA–PD plan under part C, of—

''(i) the product, for each such sponsor or organization, of—

''(I) the sum of all rebates, discounts, or other price concessions (not taking into account any rebate provided under paragraph (2) for such dosage form and strength of the drug dispensed, calculated on a per-unit basis, but only to the extent that any such rebate, discount, or other price concession applies equally to drugs dispensed to full-benefit dual eligible Medicare drug plan enrollees and drugs dispensed to PDP and MA–PD enrollees who are not full-benefit dual eligible individuals; and

''(II) the number of the units of such dosage and strength of the drug dispensed during the rebate period to full-benefit dual eligible individuals enrolled in the prescription drug plans administered by the PDP sponsor or the MA–PD plans administered by the MA–PD organization; divided by

''(ii) the total number of units of such dosage and strength of the drug dispensed during the rebate period to full-benefit dual eligible individuals enrolled in all prescription drug plans administered by PDP sponsors and all MA–PD plans administered by MA–PD organizations.

''(4) LENGTH OF AGREEMENT.—The provisions of paragraph (4) of section 1927(b) (other than clauses (iv) and (v) of subparagraph (B)) shall apply to rebate agreements under this subsection in the same manner as such paragraph applies to a rebate agreement under such section.

''(5) OTHER TERMS AND CONDITIONS.—The Secretary shall establish other terms and conditions of the rebate agreement under this subsection, including terms and conditions related to compliance, that are consistent with this subsection.

''(6) DEFINITIONS.—In this subsection and section 1860D–12(b)(7):

''(A) FULL-BENEFIT DUAL ELIGIBLE INDIVIDUAL.—The term 'full-benefit dual eligible individual' has the meaning given such term in section 1935(c)(6).

''(B) REBATE PERIOD.—The term 'rebate period' has the meaning given such term in section 1927(k)(8).''.

(2) REPORTING REQUIREMENT FOR THE DETERMINATION AND PAYMENT OF REBATES BY MANUFACTURES RELATED TO REBATE FOR FULL-BENEFIT DUAL ELIGIBLE MEDICARE DRUG PLAN ENROLLEES.—

(A) REQUIREMENTS FOR PDP SPONSORS.—Section 1860D–12(b) of the Social Security Act (42 U.S.C. 1395w–112(b)) is amended by adding at the end the following new paragraph:

''(7) REPORTING REQUIREMENT FOR THE DETERMINATION AND PAYMENT OF REBATES BY MANUFACTURERS RELATED TO REBATE FOR FULL-BENEFIT DUAL ELIGIBLE MEDICARE DRUG PLAN ENROLLEES.—

''(A) IN GENERAL.—For purposes of the rebate under section 1860D–2(f) for contract years beginning on or after January 1, 2011, each contract entered into with a PDP sponsor under this part with respect to a prescription drug plan shall require that the sponsor comply with subparagraphs (B) and (C).

''(B) REPORT FORM AND CONTENTS.—Not later than 60 days after the end of each rebate period (as defined in section 1860D–2(f)(6)(B)) within such a contract year to which such section applies, a PDP sponsor of a prescription drug plan under this part shall report to each manufacturer—

''(i) information (by National Drug Code number) on the total number of units of each dosage, form, and strength of each drug of such manufacturer dispensed to full-benefit dual eligible Medicare drug plan enrollees under any prescription drug plan operated by the PDP sponsor during the rebate period;

''(ii) information on the price discounts, price concessions, and rebates for such drugs for such form, strength, and period;

''(iii) information on the extent to which such price discounts, price concessions, and rebates apply equally to full-benefit dual eligible Medicare drug plan enrollees and PDP enrollees who are not

full-benefit dual eligible Medicare drug plan enrollees; and

''(iv) any additional information that the Secretary determines is necessary to enable the Secretary to calculate the average Medicare drug program full-benefit dual eligible rebate amount (as defined in paragraph (3)(C) of such section), and to determine the amount of the rebate required under this section, for such form, strength, and period.

Such report shall be in a form consistent with a standard reporting format established by the Secretary.

''(C) SUBMISSION TO SECRETARY.—Each PDP sponsor shall promptly transmit a copy of the information reported under subparagraph (B) to the Secretary for the purpose of audit oversight and evaluation.

''(D) CONFIDENTIALITY OF INFORMATION.—The provisions of subparagraph (D) of section 1927(b)(3), relating to confidentiality of information, shall apply to information reported by PDP sponsors under this paragraph in the same manner that such provisions apply to in-

formation disclosed by manufacturers or wholesalers under such section, except—

''(i) that any reference to 'this section' in clause (i) of such subparagraph shall be treated as being a reference to this section;

''(ii) the reference to the Director of the Congressional Budget Office in clause (iii) of such subparagraph shall be treated as including a reference to the Medicare Payment Advisory Commission; and

''(iii) clause (iv) of such subparagraph shall not apply.

''(E) OVERSIGHT.—Information reported under this paragraph may be used by the Inspector General of the Department of Health and Human Services for the statutorily authorized purposes of audit, investigation, and evaluations.

''(F) PENALTIES FOR FAILURE TO PROVIDE TIMELY INFORMATION AND PROVISION OF FALSE INFORMATION.—In the case of a PDP sponsor—

''(i) that fails to provide information required under subparagraph (B) on a

timely basis, the sponsor is subject to a civil money penalty in the amount of $10,000 for each day in which such information has not been provided; or

''(ii) that knowingly (as defined in section 1128A(i)) provides false information under such subparagraph, the sponsor is subject to a civil money penalty in an amount not to exceed $100,000 for each item of false information.

Such civil money penalties are in addition to other penalties as may be prescribed by law. The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under this subparagraph in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).''.

(B) APPLICATION TO MA ORGANIZATIONS.—Section 1857(f)(3) of the Social Security Act (42 U.S.C. 1395w–27(f)(3)) is amended by adding at the end the following:

''(D) REPORTING REQUIREMENT RELATED TO REBATE FOR FULL-BENEFIT DUAL ELIGIBLE MEDICARE DRUG PLAN ENROLLEES.—Section 1860D–12(b)(7).''.

(3) DEPOSIT OF REBATES INTO MEDICARE PRESCRIPTION DRUG ACCOUNT.—Section 1860D–16(c) of such Act (42 U.S.C. 1395w–116(c)) is amended by adding at the end the following new paragraph:

''(6) REBATE FOR FULL-BENEFIT DUAL ELIGIBLE MEDICARE DRUG PLAN ENROLLEES.—Amounts paid under a rebate agreement under section 1860D–2(f) shall be deposited into the Account and shall be used to pay for all or part of the gradual elimination of the coverage gap under section 1860D–2(b)(7).''.

SEC. 1182. DISCOUNTS FOR CERTAIN PART D DRUGS IN ORIGINAL COVERAGE GAP.

Section 1860D–2 of the Social Security Act (42 U.S.C. 1395w–102), as amended by section 1181(a), is amended—

(1) in subsection (b)(4)(C)(ii), by inserting ''subject to subsection (g)(2)(C),'' after ''(ii)'';

(2) in subsection (e)(1), in the matter before subparagraph (A), by striking ''subsection (f)'' and inserting ''subsections (f) and (g)'' after ''this subsection''; and

(3) by adding at the end the following new subsection:

''(g) REQUIREMENT FOR MANUFACTURER DISCOUNT AGREEMENT FOR CERTAIN QUALIFYING DRUGS.—

''(1) IN GENERAL.—In this part, the term 'covered part D drug' does not include any drug or biologic that is manufactured by a manufacturer that has not entered into and have in effect for all qualifying drugs (as defined in paragraph (5)(A)) a discount agreement described in paragraph (2).

''(2) DISCOUNT AGREEMENT.—

''(A) PERIODIC DISCOUNTS.—A discount agreement under this paragraph shall require the manufacturer involved to provide, to each PDP sponsor with respect to a prescription drug plan or each MA organization with respect to each MA–PD plan, a discount in an amount specified in paragraph (3) for qualifying drugs (as defined in paragraph (5)(A)) of the manufacturer dispensed to a qualifying enrollee after December 31, 2010, insofar as the individual is in the original gap in coverage (as defined in paragraph (5)(E)).

''(B) DISCOUNT AGREEMENT.—Insofar as not inconsistent with this subsection, the Secretary shall establish terms and conditions of such agreement, including terms and conditions

relating to compliance, similar to the terms and conditions for rebate agreements under paragraphs (2), (3), and (4) of section 1927(b), except that—

''(i) discounts shall be applied under this subsection to prescription drug plans and MA–PD plans instead of State plans under title XIX;

''(ii) PDP sponsors and MA organizations shall be responsible, instead of States, for provision of necessary utilization information to drug manufacturers; and

''(iii) sponsors and MA organizations shall be responsible for reporting information on drug-component negotiated price, instead of other manufacturer prices.

''(C) COUNTING DISCOUNT TOWARD TRUE OUT-OF-POCKET COSTS.—Under the discount agreement, in applying subsection (b)(4), with regard to subparagraph (C)(i) of such subsection, if a qualified enrollee purchases the qualified drug insofar as the enrollee is in an actual gap of coverage (as defined in paragraph (5)(D)), the amount of the discount under the

agreement shall be treated and counted as costs incurred by the plan enrollee.

''(3) DISCOUNT AMOUNT.—The amount of the discount specified in this paragraph for a discount period for a plan is equal to 50 percent of the amount of the drug-component negotiated price (as defined in paragraph (5)(C)) for qualifying drugs for the period involved.

''(4) ADDITIONAL TERMS.—In the case of a discount provided under this subsection with respect to a prescription drug plan offered by a PDP sponsor or an MA–PD plan offered by an MA organization, if a qualified enrollee purchases the qualified drug—

''(A) insofar as the enrollee is in an actual gap of coverage (as defined in paragraph (5)(D)), the sponsor or plan shall provide the discount to the enrollee at the time the enrollee pays for the drug; and

''(B) insofar as the enrollee is in the portion of the original gap in coverage (as defined in paragraph (5)(E)) that is not in the actual gap in coverage, the discount shall not be applied against the negotiated price (as defined in subsection (d)(1)(B)) for the purpose of calculating the beneficiary payment.

''(5) DEFINITIONS.—In this subsection:

''(A) QUALIFYING DRUG.—The term 'qualifying drug' means, with respect to a prescription drug plan or MA–PD plan, a drug or biological product that—

''(i)(I) is a drug produced or distributed under an original new drug application approved by the Food and Drug Administration, including a drug product marketed by any cross-licensed producers or distributors operating under the new drug application;

''(II) is a drug that was originally marketed under an original new drug application approved by the Food and Drug Administration; or

''(III) is a biological product as approved under Section 351(a) of the Public Health Services Act;

''(ii) is covered under the formulary of the plan; and

''(iii) is dispensed to an individual who is in the original gap in coverage.

''(B) QUALIFYING ENROLLEE.—The term 'qualifying enrollee' means an individual en-

rolled in a prescription drug plan or MA–PD plan other than such an individual who is a subsidy-eligible individual (as defined in section 1860D–14(a)(3)).

''(C) DRUG-COMPONENT NEGOTIATED PRICE.—The term 'drug-component negotiated price' means, with respect to a qualifying drug, the negotiated price (as defined in subsection (d)(1)(B)), as determined without regard to any dispensing fee, of the drug under the prescription drug plan or MA–PD plan involved.

''(D) ACTUAL GAP IN COVERAGE.—The term 'actual gap in coverage' means the gap in prescription drug coverage that occurs between the initial coverage limit (as modified under subparagraph (B) of subsection (b)(7)) and the annual out-of-pocket threshold (as modified under subparagraph (C) of such subsection).

''(E) ORIGINAL GAP IN COVERAGE.—The term 'original in gap coverage' means the gap in prescription drug coverage that would occur between the initial coverage limit (described in subsection (b)(3)) and the out-of-pocket threshold (as defined in subsection (b)(4))(B) if subsection (b)(7) did not apply.''.

SEC. 1183. REPEAL OF PROVISION RELATING TO SUBMISSION OF CLAIMS BY PHARMACIES LOCATED IN OR CONTRACTING WITH LONG-TERM CARE FACILITIES.

(a) PART D SUBMISSION.—Section 1860D–12(b) of the Social Security Act (42 U.S.C. 1395w–112(b)), as amended by section 172(a)(1) of Public Law 110–275, is amended by striking paragraph (5) and redesignating paragraph (6) and paragraph (7), as added by section 1181(b)(2), as paragraph (5) and paragraph (6), respectively.

(b) SUBMISSION TO MA–PD PLANS.—Section 1857(f)(3) of the Social Security Act (42 U.S.C. 1395w-27(f)(3)), as added by section 171(b) of Public Law 110–275 and amended by section 172(a)(2) of such Public Law, is amended by striking subparagraph (B) and redesignating subparagraph (C) as subparagraph (B).

(c) EFFECTIVE DATE.—The amendments made by this section shall apply for contract years beginning with 2010.

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.

(a) IN GENERAL.—Section 1860D–2(b)(4)(C) of the Social Security Act (42 U.S.C. 1395w–102(b)(4)(C)) is amended—

(1) in clause (i), by striking ''and'' at the end;

(2) in clause (ii)—

(A) by striking ''such costs shall be treated as incurred only if'' and inserting ''subject to clause (iii), such costs shall be treated as incurred only if'';

(B) by striking '', under section 1860D–14, or under a State Pharmaceutical Assistance Program''; and

(C) by striking the period at the end and inserting ''; and''; and

(3) by inserting after clause (ii) the following new clause:

''(iii) such costs shall be treated as incurred and shall not be considered to be reimbursed under clause (ii) if such costs are borne or paid—

''(I) under section 1860D–14;

"(II) under a State Pharmaceutical Assistance Program;

"(III) by the Indian Health Service, an Indian tribe or tribal organization, or an urban Indian organization (as defined in section 4 of the Indian Health Care Improvement Act); or

"(IV) under an AIDS Drug Assistance Program under part B of title XXVI of the Public Health Service Act.".

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to costs incurred on or after January 1, 2011.

SEC. 1185. PERMITTING MID-YEAR CHANGES IN ENROLLMENT FOR FORMULARY CHANGES THAT ADVERSELY IMPACT AN ENROLLEE.

(a) IN GENERAL.—Section 1860D–1(b)(3) of the Social Security Act (42 U.S.C. 1395w–101(b)(3)) is amended by adding at the end the following new subparagraph:

"(F) CHANGE IN FORMULARY RESULTING IN INCREASE IN COST-SHARING.—

"(i) IN GENERAL.—Except as provided in clause (ii), in the case of an individual enrolled in a prescription drug plan

(or MA–PD plan) who has been prescribed and is using a covered part D drug while so enrolled, if the formulary of the plan is materially changed (other than at the end of a contract year) so to reduce the coverage (or increase the cost-sharing) of the drug under the plan.

''(ii) EXCEPTION.—Clause (i) shall not apply in the case that a drug is removed from the formulary of a plan because of a recall or withdrawal of the drug issued by the Food and Drug Administration, because the drug is replaced with a generic drug that is a therapeutic equivalent, or because of utilization management applied to—

''(I) a drug whose labeling includes a boxed warning required by the Food and Drug Administration under section 210.57(c)(1) of title 21, Code of Federal Regulations (or a successor regulation); or

''(II) a drug required under subsection (c)(2) of section 505–1 of the Federal Food, Drug, and Cosmetic

Act to have a Risk Evaluation and Management Strategy that includes elements under subsection (f) of such section.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to contract years beginning on or after January 1, 2011.

Subtitle F—Medicare Rural Access Protections

SEC. 1191. TELEHEALTH EXPANSION AND ENHANCEMENTS.

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(a) ADDITIONAL TELEHEALTH SITE.——

(1) IN GENERAL.—Paragraph (4)(C)(ii) of section 1834(m) of the Social Security Act (42 U.S.C. 1395m(m)) is amended by adding at the end the following new subclause:

''(IX) A renal dialysis facility.''

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to services furnished on or after January 1, 2011.

(b) TELEHEALTH ADVISORY COMMITTEE.—

(1) ESTABLISHMENT.—Section 1868 of the Social Security Act (42 U.S.C. 1395ee) is amended—

(A) in the heading, by adding at the end the following: ''TELEHEALTH ADVISORY COMMITTEE''; and

(B) by adding at the end the following new subsection:

''(c) TELEHEALTH ADVISORY COMMITTEE.—

''(1) IN GENERAL.—The Secretary shall appoint a Telehealth Advisory Committee (in this subsection referred to as the 'Advisory Committee') to make recommendations to the Secretary on policies of the Centers for Medicare & Medicaid Services regarding telehealth services as established under section 1834(m), including the appropriate addition or deletion of services (and HCPCS codes) to those specified in paragraphs (4)(F)(i) and (4)(F)(ii) of such section and for authorized payment under paragraph (1) of such section.

''(2) MEMBERSHIP; TERMS.—

''(A) MEMBERSHIP.—

''(i) IN GENERAL.—The Advisory Committee shall be composed of 9 members, to be appointed by the Secretary, of whom—

''(I) 5 shall be practicing physicians;

''(II) 2 shall be practicing non-physician health care practitioners; and

''(III) 2 shall be administrators of telehealth programs.

''(ii) REQUIREMENTS FOR APPOINTING MEMBERS.—In appointing members of the Advisory Committee, the Secretary shall—

''(I) ensure that each member has prior experience with the practice of telemedicine or telehealth;

''(II) give preference to individuals who are currently providing telemedicine or telehealth services or who are involved in telemedicine or telehealth programs;

''(III) ensure that the membership of the Advisory Committee represents a balance of specialties and geographic regions; and

''(IV) take into account the recommendations of stakeholders.

''(B) TERMS.—The members of the Advisory Committee shall serve for such term as the Secretary may specify.

''(C) CONFLICTS OF INTEREST.—An advisory committee member may not participate with respect to a particular matter considered in an advisory committee meeting if such member (or an immediate family member of such member) has a financial interest that could be affected by the advice given to the Secretary with respect to such matter.

''(3) MEETINGS.—The Advisory Committee shall meet twice each calendar year and at such other times as the Secretary may provide.

''(4) PERMANENT COMMITTEE.—Section 14 of the Federal Advisory Committee Act (5 U.S.C. App.) shall not apply to the Advisory Committee.''

(2) FOLLOWING RECOMMENDATIONS.—Section 1834(m)(4)(F) of such Act (42 U.S.C. 1395m(m)(4)(F)) is amended by adding at the end the following new clause:

''(iii) RECOMMENDATIONS OF THE TELEHEALTH ADVISORY COMMITTEE.—In making determinations under clauses (i) and (ii), the Secretary shall take into ac-

count the recommendations of the Telehealth Advisory Committee (established under section 1868(c)) when adding or deleting services (and HCPCS codes) and in establishing policies of the Centers for Medicare & Medicaid Services regarding the delivery of telehealth services. If the Secretary does not implement such a recommendation, the Secretary shall publish in the Federal Register a statement regarding the reason such recommendation was not implemented.''

(3) WAIVER OF ADMINISTRATIVE LIMITATION.—The Secretary of Health and Human Services shall establish the Telehealth Advisory Committee under the amendment made by paragraph (1) notwithstanding any limitation that may apply to the number of advisory committees that may be established (within the Department of Health and Human Services or otherwise).

SEC. 1192. EXTENSION OF OUTPATIENT HOLD HARMLESS PROVISION.

Section 1833(t)(7)(D)(i) of the Social Security Act (42 U.S.C. 1395l(t)(7)(D)(i)) is amended—

(1) in subclause (II)—

(A) in the first sentence, by striking ''`2010''and inserting ''2012''; and

(B) in the second sentence, by striking ''or 2009'' and inserting '', 2009, 2010, or 2011''; and

(2) in subclause (III), by striking ''January 1, 2010'' and inserting ''January 1, 2012''.

SEC. 1193. EXTENSION OF SECTION 508 HOSPITAL RECLASSIFICATIONS.

Subsection (a) of section 106 of division B of the Tax Relief and Health Care Act of 2006 (42 U.S.C. 1395 note), as amended by section 117 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (Public Law 110–173) and section 124 of the Medicare Improvements for Patients and Providers Act of 2008 (Public Law 110–275), is amended by striking ''September 30, 2009'' and inserting ''September 30, 2011''.

SEC. 1194. EXTENSION OF GEOGRAPHIC FLOOR FOR WORK.

Section 1848(e)(1)(E) of the Social Security Act (42 U.S.C. 1395w–4(e)(1)(E)) is amended by striking ''before January 1, 2010'' and inserting ''before January 1, 2012''.

SEC. 1195. EXTENSION OF PAYMENT FOR TECHNICAL COMPONENT OF CERTAIN PHYSICIAN PATHOLOGY SERVICES.

Section 542(c) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (as enacted into law by section 1(a)(6) of Public Law 106–554), as amended by section 732 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (42 U.S.C. 1395w–4 note), section 104 of division B of the Tax Relief and Health Care Act of 2006 (42 U.S.C. 1395w–4 note), section 104 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (Public Law 110–173), and section 136 of the Medicare Improvements for Patients and Providers Act of 1008 (Public Law 110–275), is amended by striking ''and 2009'' and inserting ''2009, 2010, and 2011''.

SEC. 1196. EXTENSION OF AMBULANCE ADD-ONS.

(a) IN GENERAL.—Section 1834(l)(13) of the Social Security Act (42 U.S.C. 1395m(l)(13)) is amended—

(1) in subparagraph (A)—

(A) in the matter preceding clause (i), by striking ''before January 1, 2010'' and inserting ''before January 1, 2012''; and

(B) in each of clauses (i) and (ii), by striking ''before January 1, 2010'' and inserting ''before January 1, 2012''.

(b) AIR AMBULANCE IMPROVEMENTS.—Section 146(b)(1) of the Medicare Improvements for Patients and Providers Act of 2008 (Public Law 110–275) is amended by striking ''ending on December 31, 2009'' and inserting ''ending on December 31, 2011''.

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.

(a) APPLICATION OF HIGHEST LEVEL PERMITTED UNDER LIS TO ALL SUBSIDY ELIGIBLE INDIVIDUALS.—

(1) IN GENERAL.—Section 1860D–14(a)(1) of the Social Security Act (42 U.S.C. 1395w–114(a)(1)) is amended in the matter before subparagraph (A), by inserting ''(or, beginning with 2012, paragraph (3)(E))'' after ''paragraph (3)(D)''.

(2) ANNUAL INCREASE IN LIS RESOURCE TEST.—Section 1860D–14(a)(3)(E)(i) of such Act (42 U.S.C. 1395w–114(a)(3)(E)(i)) is amended—

(A) by striking ''and'' at the end of subclause (I);

(B) in subclause (II), by inserting ''(before 2012)'' after ''subsequent year'';

(C) by striking the period at the end of subclause (II) and inserting a semicolon;

(D) by inserting after subclause (II) the following new subclauses:

''(III) for 2012, $17,000 (or $34,000 in the case of the combined value of the individual's assets or resources and the assets or resources of the individual's spouse); and

''(IV) for a subsequent year, the dollar amounts specified in this subclause (or subclause (III)) for the previous year increased by the annual percentage increase in the consumer price index (all items; U.S. city average) as of September of such previous year.''; and

(E) in the last sentence, by inserting ''or (IV)'' after ''subclause (II)''.

(3) APPLICATION OF LIS TEST UNDER MEDICARE SAVINGS PROGRAM.—Section 1905(p)(1)(C) of such Act (42 U.S.C. 1396d(p)(1)(C)) is amended—

(A) by striking ''effective beginning with January 1, 2010'' and inserting ''effective for the period beginning with January 1, 2010, and ending with December 31, 2011''; and

(B) by inserting before the period at the end the following: ''or, effective beginning with January 1, 2012, whose resources (as so determined) do not exceed the maximum resource level applied for the year under subparagraph (E) of section 1860D–14(a)(3) (determined without regard to the life insurance policy exclusion provided under subparagraph (G) of such section) applicable to an individual or to the individual and the individual's spouse (as the case may be)''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to eligibility determinations for income-related subsidies and medicare cost-sharing furnished for periods beginning on or after January 1, 2012.

SEC. 1202. ELIMINATION OF PART D COST-SHARING FOR CERTAIN NON-INSTITUTIONALIZED FULL-BENEFIT DUAL ELIGIBLE INDIVIDUALS.

(a) IN GENERAL.—Section 1860D–14(a)(1)(D)(i) of the Social Security Act (42 U.S.C. 1395w–114(a)(1)(D)(i)) is amended—

(1) by striking ''INSTITUTIONALIZED INDIVIDUALS.—In'' and inserting ''ELIMINATION OF COST-SHARING FOR CERTAIN FULL-BENEFIT DUAL ELIGIBLE INDIVIDUALS.—

''(I) INSTITUTIONALIZED INDIVIDUALS.—In''; and

(2) by adding at the end the following new subclause:

''(II) CERTAIN OTHER INDIVIDUALS.—In the case of an individual who is a full-benefit dual eligible individual and with respect to whom there has been a determination that but for the provision of home and community based care (whether under section 1915, 1932, or under a waiver under section 1115) the individual would require the level of care provided in a hospital or a nursing facility or intermediate care facility for the mentally

retarded the cost of which could be reimbursed under the State plan under title XIX, the elimination of any beneficiary coinsurance described in section 1860D–2(b)(2) (for all amounts through the total amount of expenditures at which benefits are available under section 1860D–2(b)(4)).''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to drugs dispensed on or after January 1, 2011.

SEC. 1203. ELIMINATING BARRIERS TO ENROLLMENT.

(a) ADMINISTRATIVE VERIFICATION OF INCOME AND RESOURCES UNDER THE LOW-INCOME SUBSIDY PROGRAM.—

(1) IN GENERAL.—Clause (iii) of section 1860D–14(a)(3)(E) of the Social Security Act (42 U.S.C. 1395w–114(a)(3)(E)) is amended to read as follows:

''(iii) CERTIFICATION OF INCOME AND RESOURCES.—For purposes of applying this section—

''(I) an individual shall be permitted to apply on the basis of self-

certification of income and resources; and

''(II) matters attested to in the application shall be subject to appropriate methods of verification without the need of the individual to provide additional documentation, except in extraordinary situations as determined by the Commissioner.''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply beginning January 1, 2010.

(b) 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.—For provision authorizing disclosure of return information to facilitate identification of individuals likely to be ineligible for low-income subsidies under Medicare prescription drug program, see section 1801.

SEC. 1204. ENHANCED OVERSIGHT RELATING TO REIMBURSEMENTS FOR RETROACTIVE LOW INCOME SUBSIDY ENROLLMENT.

(a) IN GENERAL.—In the case of a retroactive LIS enrollment beneficiary who is enrolled under a prescription drug plan under part D of title XVIII of the Social Security Act (or an MA–PD plan under part C of such title), the beneficiary (or any eligible third party) is entitled to reimbursement by the plan for covered drug costs incurred by the beneficiary during the retroactive coverage period of the beneficiary in accordance with subsection (b) and in the case of such a beneficiary described in subsection (c)(4)(A)(i), such reimbursement shall be made automatically by the plan upon receipt of appropriate notice the beneficiary is eligible for assistance described in such subsection (c)(4)(A)(i) without further information required to be filed with the plan by the beneficiary.

(b) ADMINISTRATIVE REQUIREMENTS RELATING TO REIMBURSEMENTS.—

(1) LINE-ITEM DESCRIPTION.—Each reimbursement made by a prescription drug plan or MA–PD plan under subsection (a) shall include a line-item description of the items for which the reimbursement is made.

(2) TIMING OF REIMBURSEMENTS.—A prescription drug plan or MA–PD plan must make a reim-

bursement under subsection (a) to a retroactive LIS enrollment beneficiary, with respect to a claim, not later than 45 days after—

(A) in the case of a beneficiary described in subsection (c)(4)(A)(i), the date on which the plan receives notice from the Secretary that the beneficiary is eligible for assistance described in such subsection; or

(B) in the case of a beneficiary described in subsection (c)(4)(A)(ii), the date on which the beneficiary files the claim with the plan.

(3) REPORTING REQUIREMENT.—For each month beginning with January 2011, each prescription drug plan and each MA–PD plan shall report to the Secretary the following:

(A) The number of claims the plan has readjudicated during the month due to a beneficiary becoming retroactively eligible for subsidies available under section 1860D–14 of the Social Security Act.

(B) The total value of the readjudicated claim amount for the month.

(C) The Medicare Health Insurance Claims Number of beneficiaries for whom claims were readjudicated.

(D) For the claims described in subparagraphs (A) and (B), an attestation to the Administrator of the Centers for Medicare & Medicaid Services of the total amount of reimbursement the plan has provided to beneficiaries for premiums and cost-sharing that the beneficiary overpaid for which the plan received payment from the Centers for Medicare & Medicaid Services.

(c) DEFINITIONS.—For purposes of this section:

(1) COVERED DRUG COSTS.—The term ''covered drug costs'' means, with respect to a retroactive LIS enrollment beneficiary enrolled under a prescription drug plan under part D of title XVIII of the Social Security Act (or an MA–PD plan under part C of such title), the amount by which—

(A) the costs incurred by such beneficiary during the retroactive coverage period of the beneficiary for covered part D drugs, premiums, and cost-sharing under such title; exceeds

(B) such costs that would have been incurred by such beneficiary during such period if the beneficiary had been both enrolled in the plan and recognized by such plan as qualified during such period for the low income subsidy

under section 1860D–14 of the Social Security Act to which the individual is entitled.

(2) ELIGIBLE THIRD PARTY.—The term ''eligible third party'' means, with respect to a retroactive LIS enrollment beneficiary, an organization or other third party that is owed payment on behalf of such beneficiary for covered drug costs incurred by such beneficiary during the retroactive coverage period of such beneficiary.

(3) RETROACTIVE COVERAGE PERIOD.—The term ''retroactive coverage period'' means—

(A) with respect to a retroactive LIS enrollment beneficiary described in paragraph (4)(A)(i), the period—

(i) beginning on the effective date of the assistance described in such paragraph for which the individual is eligible; and

(ii) ending on the date the plan effectuates the status of such individual as so eligible; and

(B) with respect to a retroactive LIS enrollment beneficiary described in paragraph (4)(A)(ii), the period—

(i) beginning on the date the individual is both entitled to benefits under

part A, or enrolled under part B, of title XVIII of the Social Security Act and eligible for medical assistance under a State plan under title XIX of such Act; and

(ii) ending on the date the plan effectuates the status of such individual as a full-benefit dual eligible individual (as defined in section 1935(c)(6) of such Act).

(4) RETROACTIVE LIS ENROLLMENT BENEFICIARY.—

(A) IN GENERAL.—The term ''retroactive LIS enrollment beneficiary'' means an individual who—

(i) is enrolled in a prescription drug plan under part D of title XVIII of the Social Security Act (or an MA–PD plan under part C of such title) and subsequently becomes eligible as a full-benefit dual eligible individual (as defined in section 1935(c)(6) of such Act), an individual receiving a low-income subsidy under section 1860D–14 of such Act, an individual receiving assistance under the Medicare Savings Program implemented under clauses (i), (iii), and (iv) of section

1902(a)(10)(E) of such Act, or an individual receiving assistance under the supplemental security income program under section 1611 of such Act; or

(ii) subject to subparagraph (B)(i), is a full-benefit dual eligible individual (as defined in section 1935(c)(6) of such Act) who is automatically enrolled in such a plan under section 1860D–1(b)(1)(C) of such Act.

(B) EXCEPTION FOR BENEFICIARIES ENROLLED IN RFP PLAN.—

(i) IN GENERAL.—In no case shall an individual described in subparagraph (A)(ii) include an individual who is enrolled, pursuant to a RFP contract described in clause (ii), in a prescription drug plan offered by the sponsor of such plan awarded such contract.

(ii) RFP CONTRACT DESCRIBED.—The RFP contract described in this section is a contract entered into between the Secretary and a sponsor of a prescription drug plan pursuant to the Centers for Medicare & Medicaid Services' request for proposals

issued on February 17, 2009, relating to Medicare part D retroactive coverage for certain low income beneficiaries, or a similar subsequent request for proposals.

SEC. 1205. INTELLIGENT ASSIGNMENT IN ENROLLMENT.

(a) IN GENERAL.—Section 1860D–1(b)(1)(C) of the Social Security Act (42 U.S.C. 1395w–101(b)(1)(C)) is amended by adding after ''PDP region'' the following: ''or through use of an intelligent assignment process that is designed to maximize the access of such individual to necessary prescription drugs while minimizing costs to such individual and to the program under this part to the greatest extent possible. In the case the Secretary enrolls such individuals through use of an intelligent assignment process, such process shall take into account the extent to which prescription drugs necessary for the individual are covered in the case of a PDP sponsor of a prescription drug plan that uses a formulary, the use of prior authorization or other restrictions on access to coverage of such prescription drugs by such a sponsor, and the overall quality of a prescription drug plan as measured by quality ratings established by the Secretary.''

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect for contract years beginning with 2012.

SEC. 1206. SPECIAL ENROLLMENT PERIOD AND AUTOMATIC ENROLLMENT PROCESS FOR CERTAIN SUBSIDY ELIGIBLE INDIVIDUALS.

(a) SPECIAL ENROLLMENT PERIOD.—Section 1860D–1(b)(3)(D) of the Social Security Act (42 U.S.C. 1395w–101(b)(3)(D)) is amended to read as follows:

''(D) SUBSIDY ELIGIBLE INDIVIDUALS.—In the case of an individual (as determined by the Secretary) who is determined under subparagraph (B) of section 1860D–14(a)(3) to be a subsidy eligible individual.''.

(b) AUTOMATIC ENROLLMENT.—Section 1860D–1(b)(1) of the Social Security Act (42 U.S.C. 1395w–101(b)(1)) is amended by adding at the end the following new subparagraph:

''(D) SPECIAL RULE FOR SUBSIDY ELIGIBLE INDIVIDUALS.—The process established under subparagraph (A) shall include, in the case of an individual described in section 1860D–1(b)(3)(D) who fails to enroll in a prescription drug plan or an MA–PD plan during the special enrollment established under such section applicable to such individual, the application of the assignment process described in subparagraph (C) to such individual in the same manner as such assignment process ap-

plies to a part D eligible individual described in such subparagraph (C). Nothing in the previous sentence shall prevent an individual described in such sentence from declining enrollment in a plan determined appropriate by the Secretary (or in the program under this part) or from changing such enrollment.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to subsidy determinations made for months beginning with January 2011.

SEC. 1207. APPLICATION OF MA PREMIUMS PRIOR TO REBATE IN CALCULATION OF LOW INCOME SUBSIDY BENCHMARK.

(a) IN GENERAL.—Section 1860D–14(b)(2)(B)(iii) of the Social Security Act (42 U.S.C. 1395w–114(b)(2)(B)(iii)) is amended by inserting before the period the following: ''before the application of the monthly rebate computed under section 1854(b)(1)(C)(i) for that plan and year involved''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to subsidy determinations made for months beginning with January 2011.

Subtitle B—Reducing Health Disparities

SEC. 1221. ENSURING EFFECTIVE COMMUNICATION IN MEDICARE.

(a) ENSURING EFFECTIVE COMMUNICATION BY THE CENTERS FOR MEDICARE & MEDICAID SERVICES.—

(1) STUDY ON MEDICARE PAYMENTS FOR LANGUAGE SERVICES.—The Secretary of Health and Human Services shall conduct a study that examines the extent to which Medicare service providers utilize, offer, or make available language services for beneficiaries who are limited English proficient and ways that Medicare should develop payment systems for language services.

(2) ANALYSES.—The study shall include an analysis of each of the following:

(A) How to develop and structure appropriate payment systems for language services for all Medicare service providers.

(B) The feasibility of adopting a payment methodology for on-site interpreters, including interpreters who work as independent contractors and interpreters who work for agencies that provide on-site interpretation, pursuant to which such interpreters could directly bill Medi-

care for services provided in support of physician office services for an LEP Medicare patient.

(C) The feasibility of Medicare contracting directly with agencies that provide off-site interpretation including telephonic and video interpretation pursuant to which such contractors could directly bill Medicare for the services provided in support of physician office services for an LEP Medicare patient.

(D) The feasibility of modifying the existing Medicare resource-based relative value scale (RBRVS) by using adjustments (such as multipliers or add-ons) when a patient is LEP.

(E) How each of options described in a previous paragraph would be funded and how such funding would affect physician payments, a physician's practice, and beneficiary cost-sharing.

(F) The extent to which providers under parts A and B of title XVIII of the Social Security Act, MA organizations offering Medicare Advantage plans under part C of such title and PDP sponsors of a prescription drug plan under part D of such title utilize, offer, or make

available language services for beneficiaries with limited English proficiency.

(G) The nature and type of language services provided by States under title XIX of the Social Security Act and the extent to which such services could be utilized by beneficiaries and providers under title XVIII of such Act.

(3) VARIATION IN PAYMENT SYSTEM DESCRIBED.—The payment systems described in paragraph (2)(A) may allow variations based upon types of service providers, available delivery methods, and costs for providing language services including such factors as—

(A) the type of language services provided (such as provision of health care or health care related services directly in a non-English language by a bilingual provider or use of an interpreter);

(B) type of interpretation services provided (such as in-person, telephonic, video interpretation);

(C) the methods and costs of providing language services (including the costs of providing language services with internal staff or

through contract with external independent contractors or agencies, or both);

(D) providing services for languages not frequently encountered in the United States; and

(E) providing services in rural areas.

(4) REPORT.—The Secretary shall submit a report on the study conducted under subsection (a) to appropriate committees of Congress not later than 12 months after the date of the enactment of this Act.

(5) EXEMPTION FROM PAPERWORK REDUCTION ACT.—Chapter 35 of title 44, United States Code (commonly known as the ''Paperwork Reduction Act''), shall not apply for purposes of carrying out this subsection.

(6) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this subsection such sums as are necessary.

(b) HEALTH PLANS.—Section 1857(g)(1) of the Social Security Act (42 U.S.C. 1395w–27(g)(1)) is amended—

(1) by striking ''or'' at the end of subparagraph (F);

(2) by adding ''or'' at the end of subparagraph (G); and

(3) by inserting after subparagraph (G) the following new subparagraph:

''(H) fails substantially to provide language services to limited English proficient beneficiaries enrolled in the plan that are required under law;''.

SEC. 1222. DEMONSTRATION TO PROMOTE ACCESS FOR MEDICARE BENEFICIARIES WITH LIMITED ENGLISH PROFICIENCY BY PROVIDING REIMBURSEMENT FOR CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES.

(a) IN GENERAL.—Not later than 6 months after the date of the completion of the study described in section 1221(a), the Secretary, acting through the Centers for Medicare & Medicaid Services, shall carry out a demonstration program under which the Secretary shall award not fewer than 24 3-year grants to eligible Medicare service providers (as described in subsection (b)(1)) to improve effective communication between such providers and Medicare beneficiaries who are living in communities where racial and ethnic minorities, including populations that face language barriers, are underserved with respect to such services. In designing and carrying out the demonstration

the Secretary shall take into consideration the results of the study conducted under section 1221(a) and adjust, as appropriate, the distribution of grants so as to better target Medicare beneficiaries who are in the greatest need of language services. The Secretary shall not authorize a grant larger than $500,000 over three years for any grantee.

(b) ELIGIBILITY; PRIORITY.—

(1) ELIGIBILITY.—To be eligible to receive a grant under subsection (a) an entity shall—

(A) be—

(i) a provider of services under part A of title XVIII of the Social Security Act;

(ii) a service provider under part B of such title;

(iii) a part C organization offering a Medicare part C plan under part C of such title; or

(iv) a PDP sponsor of a prescription drug plan under part D of such title; and

(B) prepare and submit to the Secretary an application, at such time, in such manner, and accompanied by such additional information as the Secretary may require.

(2) PRIORITY.—

(A) DISTRIBUTION.—To the extent feasible, in awarding grants under this section, the Secretary shall award—

(i) at least 6 grants to providers of services described in paragraph (1)(A)(i);

(ii) at least 6 grants to service providers described in paragraph (1)(A)(ii);

(iii) at least 6 grants to organizations described in paragraph (1)(A)(iii); and

(iv) at least 6 grants to sponsors described in paragraph (1)(A)(iv).

(B) FOR COMMUNITY ORGANIZATIONS.—The Secretary shall give priority to applicants that have developed partnerships with community organizations or with agencies with experience in language access.

(C) VARIATION IN GRANTEES.—The Secretary shall also ensure that the grantees under this section represent, among other factors, variations in—

(i) different types of language services provided and of service providers and organizations under parts A through D of title XVIII of the Social Security Act;

(ii) languages needed and their frequency of use;

(iii) urban and rural settings;

(iv) at least two geographic regions, as defined by the Secretary; and

(v) at least two large metropolitan statistical areas with diverse populations.

(c) USE OF FUNDS.—

(1) IN GENERAL.—A grantee shall use grant funds received under this section to pay for the provision of competent language services to Medicare beneficiaries who are limited English proficient. Competent interpreter services may be provided through on-site interpretation, telephonic interpretation, or video interpretation or direct provision of health care or health care related services by a bilingual health care provider. A grantee may use bilingual providers, staff, or contract interpreters. A grantee may use grant funds to pay for competent translation services. A grantee may use up to 10 percent of the grant funds to pay for administrative costs associated with the provision of competent language services and for reporting required under subsection (e).

(2) ORGANIZATIONS.—Grantees that are part C organizations or PDP sponsors must ensure that their network providers receive at least 50 percent of the grant funds to pay for the provision of competent language services to Medicare beneficiaries who are limited English proficient, including physicians and pharmacies.

(3) DETERMINATION OF PAYMENTS FOR LANGUAGE SERVICES.—Payments to grantees shall be calculated based on the estimated numbers of limited English proficient Medicare beneficiaries in a grantee's service area utilizing—

(A) data on the numbers of limited English proficient individuals who speak English less than ''very well'' from the most recently available data from the Bureau of the Census or other State-based study the Secretary determines likely to yield accurate data regarding the number of such individuals served by the grantee; or

(B) the grantee's own data if the grantee routinely collects data on Medicare beneficiaries' primary language in a manner determined by the Secretary to yield accurate data and such data shows greater numbers of limited

English proficient individuals than the data listed in subparagraph (A).

(4) LIMITATIONS.—

(A) REPORTING.—Payments shall only be provided under this section to grantees that report their costs of providing language services as required under subsection (e) and may be modified annually at the discretion of the Secretary. If a grantee fails to provide the reports under such section for the first year of a grant, the Secretary may terminate the grant and solicit applications from new grantees to participate in the subsequent two years of the demonstration program.

(B) TYPE OF SERVICES.—

(i) IN GENERAL.—Subject to clause (ii), payments shall be provided under this section only to grantees that utilize competent bilingual staff or competent interpreter or translation services which—

(I) if the grantee operates in a State that has statewide health care interpreter standards, meet the State standards currently in effect; or

(II) if the grantee operates in a State that does not have statewide health care interpreter standards, utilizes competent interpreters who follow the National Council on Interpreting in Health Care's Code of Ethics and Standards of Practice.

(ii) EXEMPTIONS.—The requirements of clause (i) shall not apply—

(I) in the case of a Medicare beneficiary who is limited English proficient (who has been informed in the beneficiary's primary language of the availability of free interpreter and translation services) and who requests the use of family, friends, or other persons untrained in interpretation or translation and the grantee documents the request in the beneficiary's record; and

(II) in the case of a medical emergency where the delay directly associated with obtaining a competent interpreter or translation services

would jeopardize the health of the patient.

Nothing in clause (ii)(II) shall be construed to exempt emergency rooms or similar entities that regularly provide health care services in medical emergencies from having in place systems to provide competent interpreter and translation services without undue delay.

(d) ASSURANCES.—Grantees under this section shall—

(1) ensure that appropriate clinical and support staff receive ongoing education and training in linguistically appropriate service delivery;

(2) ensure the linguistic competence of bilingual providers;

(3) offer and provide appropriate language services at no additional charge to each patient with limited English proficiency at all points of contact, in a timely manner during all hours of operation;

(4) notify Medicare beneficiaries of their right to receive language services in their primary language;

(5) post signage in the languages of the commonly encountered group or groups present in the service area of the organization; and

(6) ensure that—

(A) primary language data are collected for recipients of language services; and

(B) consistent with the privacy protections provided under the regulations promulgated pursuant to section 264(c) of the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. 1320d–2 note), if the recipient of language services is a minor or is incapacitated, the primary language of the parent or legal guardian is collected and utilized.

(e) REPORTING REQUIREMENTS.—Grantees under this section shall provide the Secretary with reports at the conclusion of the each year of a grant under this section. Each report shall include at least the following information:

(1) The number of Medicare beneficiaries to whom language services are provided.

(2) The languages of those Medicare beneficiaries.

(3) The types of language services provided (such as provision of services directly in non-English

language by a bilingual health care provider or use of an interpreter).

(4) Type of interpretation (such as in-person, telephonic, or video interpretation).

(5) The methods of providing language services (such as staff or contract with external independent contractors or agencies).

(6) The length of time for each interpretation encounter.

(7) The costs of providing language services (which may be actual or estimated, as determined by the Secretary).

(f) NO COST SHARING.—Limited English proficient Medicare beneficiaries shall not have to pay cost-sharing or co-pays for language services provided through this demonstration program.

(g) EVALUATION AND REPORT.—The Secretary shall conduct an evaluation of the demonstration program under this section and shall submit to the appropriate committees of Congress a report not later than 1 year after the completion of the program. The report shall include the following:

(1) An analysis of the patient outcomes and costs of furnishing care to the limited English proficient Medicare beneficiaries participating in the

project as compared to such outcomes and costs for limited English proficient Medicare beneficiaries not participating.

(2) The effect of delivering culturally and linguistically appropriate services on beneficiary access to care, utilization of services, efficiency and cost-effectiveness of health care delivery, patient satisfaction, and select health outcomes.

(3) Recommendations, if any, regarding the extension of such project to the entire Medicare program.

(h) GENERAL PROVISIONS.—Nothing in this section shall be construed to limit otherwise existing obligations of recipients of Federal financial assistance under title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000(d) et seq.) or any other statute.

(i) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section $16,000,000 for each fiscal year of the demonstration program.

SEC. 1223. IOM REPORT ON IMPACT OF LANGUAGE ACCESS SERVICES.

(a) IN GENERAL.—The Secretary of Health and Human Services shall enter into an arrangement with the Institute of Medicine under which the Institute will pre-

pare and publish, not later than 3 years after the date of the enactment of this Act, a report on the impact of language access services on the health and health care of limited English proficient populations.

(b) CONTENTS.—Such report shall include—

(1) recommendations on the development and implementation of policies and practices by health care organizations and providers for limited English proficient patient populations;

(2) a description of the effect of providing language access services on quality of health care and access to care and reduced medical error; and

(3) a description of the costs associated with or savings related to provision of language access services.

SEC. 1224. DEFINITIONS.

In this subtitle:

(1) BILINGUAL.—The term ''bilingual'' with respect to an individual means a person who has sufficient degree of proficiency in two languages and can ensure effective communication can occur in both languages.

(2) COMPETENT INTERPRETER SERVICES.—The term ''competent interpreter services'' means a trans-language rendition of a spoken message in

which the interpreter comprehends the source language and can speak comprehensively in the target language to convey the meaning intended in the source language. The interpreter knows health and health-related terminology and provides accurate interpretations by choosing equivalent expressions that convey the best matching and meaning to the source language and captures, to the greatest possible extent, all nuances intended in the source message.

(3) COMPETENT TRANSLATION SERVICES.—The term ''competent translation services'' means a trans-language rendition of a written document in which the translator comprehends the source language and can write comprehensively in the target language to convey the meaning intended in the source language. The translator knows health and health-related terminology and provides accurate translations by choosing equivalent expressions that convey the best matching and meaning to the source language and captures, to the greatest possible extent, all nuances intended in the source document.

(4) EFFECTIVE COMMUNICATION.—The term ''effective communication'' means an exchange of information between the provider of health care or health care-related services and the limited English

proficient recipient of such services that enables limited English proficient individuals to access, understand, and benefit from health care or health care-related services.

(5) INTERPRETING/INTERPRETATION.—The terms ''interpreting'' and ''interpretation'' mean the transmission of a spoken message from one language into another, faithfully, accurately, and objectively.

(6) HEALTH CARE SERVICES.—The term ''health care services'' means services that address physical as well as mental health conditions in all care settings.

(7) HEALTH CARE-RELATED SERVICES.—The term ''health care-related services'' means human or social services programs or activities that provide access, referrals or links to health care.

(8) LANGUAGE ACCESS.—The term ''language access'' means the provision of language services to an LEP individual designed to enhance that individual's access to, understanding of or benefit from health care or health care-related services.

(9) LANGUAGE SERVICES.—The term ''language services'' means provision of health care services directly in a non-English language, interpretation, translation, and non-English signage.

(10) LIMITED ENGLISH PROFICIENT.—The term ''limited English proficient'' or ''LEP'' with respect to an individual means an individual who speaks a primary language other than English and who cannot speak, read, write or understand the English language at a level that permits the individual to effectively communicate with clinical or nonclinical staff at an entity providing health care or health care related services.

(11) MEDICARE BENEFICIARY.—The term ''Medicare beneficiary'' means an individual entitled to benefits under part A of title XVIII of the Social Security Act or enrolled under part B of such title.

(12) MEDICARE PROGRAM.—The term ''Medicare program'' means the programs under parts A through D of title XVIII of the Social Security Act.

(13) SERVICE PROVIDER.—The term ''service provider'' includes all suppliers, providers of services, or entities under contract to provide coverage, items or services under any part of title XVIII of the Social Security Act.

Subtitle C—Miscellaneous Improvements

SEC. 1231. EXTENSION OF THERAPY CAPS EXCEPTIONS PROCESS.

Section 1833(g)(5) of the Social Security Act (42 U.S.C. 1395l(g)(5)), as amended by section 141 of the Medicare Improvements for Patients and Providers Act of 2008 (Public Law 110–275), is amended by striking ''December 31, 2009'' and inserting ''December 31, 2011''.

SEC. 1232. EXTENDED MONTHS OF COVERAGE OF IMMUNOSUPPRESSIVE DRUGS FOR KIDNEY TRANSPLANT PATIENTS AND OTHER RENAL DIALYSIS PROVISIONS.

(a) PROVISION OF APPROPRIATE COVERAGE OF IMMUNOSUPPRESSIVE DRUGS UNDER THE MEDICARE PROGRAM FOR KIDNEY TRANSPLANT RECIPIENTS.—

(1) CONTINUED ENTITLEMENT TO IMMUNOSUPPRESSIVE DRUGS.—

(A) KIDNEY TRANSPLANT RECIPIENTS.—Section 226A(b)(2) of the Social Security Act (42 U.S.C. 426–1(b)(2)) is amended by inserting ''(except for coverage of immunosuppressive drugs under section 1861(s)(2)(J))'' before '', with the thirty-sixth month''.

(B) APPLICATION.—Section 1836 of such Act (42 U.S.C. 1395o) is amended—

(i) by striking ''Every individual who'' and inserting ''(a) IN GENERAL.–Every individual who''; and

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

''(b) SPECIAL RULES APPLICABLE TO INDIVIDUALS ONLY ELIGIBLE FOR COVERAGE OF IMMUNOSUPPRESSIVE DRUGS.—

''(1) IN GENERAL.—In the case of an individual whose eligibility for benefits under this title has ended on or after January 1, 2012, except for the coverage of immunosuppressive drugs by reason of section 226A(b)(2), the following rules shall apply:

''(A) The individual shall be deemed to be enrolled under this part for purposes of receiving coverage of such drugs.

''(B) The individual shall be responsible for providing for payment of the portion of the premium under section 1839 which is not covered under the Medicare savings program (as defined in section 1144(c)(7)) in order to receive such coverage.

''(C) The provision of such drugs shall be subject to the application of—

''(i) the deductible under section 1833(b); and

''(ii) the coinsurance amount applicable for such drugs (as determined under this part).

''(D) If the individual is an inpatient of a hospital or other entity, the individual is entitled to receive coverage of such drugs under this part.

''(2) ESTABLISHMENT OF PROCEDURES IN ORDER TO IMPLEMENT COVERAGE.—The Secretary shall establish procedures for—

''(A) identifying individuals that are entitled to coverage of immunosuppressive drugs by reason of section 226A(b)(2); and

''(B) distinguishing such individuals from individuals that are enrolled under this part for the complete package of benefits under this part.''.

(C) TECHNICAL AMENDMENT TO CORRECT DUPLICATE SUBSECTION DESIGNATION.—Subsection (d) of section 226A of such Act (42 U.S.C. 426–1), as added by section

201(a)(3)(D)(ii) of the Social Security Independence and Program Improvements Act of 1994 (Public Law 103–296; 108 Stat. 1497), is redesignated as subsection (d).

(2) EXTENSION OF SECONDARY PAYER REQUIREMENTS FOR ESRD BENEFICIARIES.—Section 1862(b)(1)(C) of such Act (42 U.S.C. 1395y(b)(1)(C)) is amended by adding at the end the following new sentence: ''With regard to immunosuppressive drugs furnished on or after the date of the enactment of the America's Affordable Health Choices Act of 2009, this subparagraph shall be applied without regard to any time limitation.''.

(b) MEDICARE COVERAGE FOR ESRD PATIENTS.—Section 1881 of such Act is further amended—

(1) in subsection (b)(14)(B)(iii), by inserting '', including oral drugs that are not the oral equivalent of an intravenous drug (such as oral phosphate binders and calcimimetics),'' after ''other drugs and biologicals'';

(2) in subsection (b)(14)(E)(ii)—

(A) in the first sentence—

(i) by striking ''a one-time election to be excluded from the phase-in'' and inserting ''an election, with respect to 2011,

2012, or 2013, to be excluded from the phase-in (or the remainder of the phase-in)''; and

(ii) by adding at the end the following: ''for such year and for each subsequent year during the phase-in described in clause (i)''; and

(B) in the second sentence—

(i) by striking ''January 1, 2011'' and inserting ''the first date of such year''; and

(ii) by inserting ''and at a time'' after ''form and manner''; and

(3) in subsection (h)(4)(E), by striking ''lesser'' and inserting ''greater''.

SEC. 1233. ADVANCE CARE PLANNING CONSULTATION.

(a) MEDICARE.—

(1) IN GENERAL.—Section 1861 of the Social Security Act (42 U.S.C. 1395x) is amended—

(A) in subsection (s)(2)—

(i) by striking ''and'' at the end of subparagraph (DD);

(ii) by adding ''and'' at the end of subparagraph (EE); and

(iii) by adding at the end the following new subparagraph:

''(FF) advance care planning consultation (as defined in subsection (hhh)(1));''; and

(B) by adding at the end the following new subsection:

''Advance Care Planning Consultation

''(hhh)(1) Subject to paragraphs (3) and (4), the term 'advance care planning consultation' means a consultation between the individual and a practitioner described in paragraph (2) regarding advance care planning, if, subject to paragraph (3), the individual involved has not had such a consultation within the last 5 years. Such consultation shall include the following:

''(A) An explanation by the practitioner of advance care planning, including key questions and considerations, important steps, and suggested people to talk to.

''(B) An explanation by the practitioner of advance directives, including living wills and durable powers of attorney, and their uses.

''(C) An explanation by the practitioner of the role and responsibilities of a health care proxy.

''(D) The provision by the practitioner of a list of national and State-specific resources to assist consumers and their families with advance care planning, including the national toll-free hotline, the ad-

vance care planning clearinghouses, and State legal service organizations (including those funded through the Older Americans Act of 1965).

''(E) An explanation by the practitioner of the continuum of end-of-life services and supports available, including palliative care and hospice, and benefits for such services and supports that are available under this title.

''(F)(i) Subject to clause (ii), an explanation of orders regarding life sustaining treatment or similar orders, which shall include—

''(I) the reasons why the development of such an order is beneficial to the individual and the individual's family and the reasons why such an order should be updated periodically as the health of the individual changes;

''(II) the information needed for an individual or legal surrogate to make informed decisions regarding the completion of such an order; and

''(III) the identification of resources that an individual may use to determine the requirements of the State in which such individual resides so that the treatment wishes of that individual will be carried out if the individual is un-

able to communicate those wishes, including requirements regarding the designation of a surrogate decisionmaker (also known as a health care proxy).

''(ii) The Secretary shall limit the requirement for explanations under clause (i) to consultations furnished in a State—

''(I) in which all legal barriers have been addressed for enabling orders for life sustaining treatment to constitute a set of medical orders respected across all care settings; and

''(II) that has in effect a program for orders for life sustaining treatment described in clause (iii).

''(iii) A program for orders for life sustaining treatment for a States described in this clause is a program that—

''(I) ensures such orders are standardized and uniquely identifiable throughout the State;

''(II) distributes or makes accessible such orders to physicians and other health professionals that (acting within the scope of the professional's authority under State law) may sign orders for life sustaining treatment;

''(III) provides training for health care professionals across the continuum of care about the goals and use of orders for life sustaining treatment; and

''(IV) is guided by a coalition of stakeholders includes representatives from emergency medical services, emergency department physicians or nurses, state long-term care association, state medical association, state surveyors, agency responsible for senior services, state department of health, state hospital association, home health association, state bar association, and state hospice association.

''(2) A practitioner described in this paragraph is—

''(A) a physician (as defined in subsection (r)(1)); and

''(B) a nurse practitioner or physician's assistant who has the authority under State law to sign orders for life sustaining treatments.

''(3)(A) An initial preventive physical examination under subsection (WW), including any related discussion during such examination, shall not be considered an advance care planning consultation for purposes of applying the 5-year limitation under paragraph (1).

''(B) An advance care planning consultation with respect to an individual may be conducted more frequently than provided under paragraph (1) if there is a significant change in the health condition of the individual, including diagnosis of a chronic, progressive, life-limiting disease, a life-threatening or terminal diagnosis or life-threatening injury, or upon admission to a skilled nursing facility, a long-term care facility (as defined by the Secretary), or a hospice program.

''(4) A consultation under this subsection may include the formulation of an order regarding life sustaining treatment or a similar order.

''(5)(A) For purposes of this section, the term 'order regarding life sustaining treatment' means, with respect to an individual, an actionable medical order relating to the treatment of that individual that—

''(i) is signed and dated by a physician (as defined in subsection (r)(1)) or another health care professional (as specified by the Secretary and who is acting within the scope of the professional's authority under State law in signing such an order, including a nurse practitioner or physician assistant) and is in a form that permits it to stay with the individual and be followed by health care professionals and providers across the continuum of care;

''(ii) effectively communicates the individual's preferences regarding life sustaining treatment, including an indication of the treatment and care desired by the individual;

''(iii) is uniquely identifiable and standardized within a given locality, region, or State (as identified by the Secretary); and

''(iv) may incorporate any advance directive (as defined in section 1866(f)(3)) if executed by the individual.

''(B) The level of treatment indicated under subparagraph (A)(ii) may range from an indication for full treatment to an indication to limit some or all or specified interventions. Such indicated levels of treatment may include indications respecting, among other items—

''(i) the intensity of medical intervention if the patient is pulse less, apneic, or has serious cardiac or pulmonary problems;

''(ii) the individual's desire regarding transfer to a hospital or remaining at the current care setting;

''(iii) the use of antibiotics; and

''(iv) the use of artificially administered nutrition and hydration.''.

(2) PAYMENT.—Section 1848(j)(3) of such Act (42 U.S.C. 1395w-4(j)(3)) is amended by inserting ''(2)(FF),'' after ''(2)(EE),''.

(3) FREQUENCY LIMITATION.—Section 1862(a) of such Act (42 U.S.C. 1395y(a)) is amended—

(A) in paragraph (1)—

(i) in subparagraph (N), by striking ''and'' at the end;

(ii) in subparagraph (O) by striking the semicolon at the end and inserting '', and''; and

(iii) by adding at the end the following new subparagraph:

''(P) in the case of advance care planning consultations (as defined in section 1861(hhh)(1)), which are performed more frequently than is covered under such section;''; and

(B) in paragraph (7), by striking ''or (K)'' and inserting ''(K), or (P)''.

(4) EFFECTIVE DATE.—The amendments made by this subsection shall apply to consultations furnished on or after January 1, 2011.

(b) EXPANSION OF PHYSICIAN QUALITY REPORTING INITIATIVE FOR END OF LIFE CARE.—

(1) PHYSICIAN'S QUALITY REPORTING INITIATIVE.—Section 1848(k)(2) of the Social Security Act (42 U.S.C. 1395w–4(k)(2)) is amended by adding at the end the following new paragraphs:

''(3) PHYSICIAN'S QUALITY REPORTING INITIATIVE.—

''(A) IN GENERAL.—For purposes of reporting data on quality measures for covered professional services furnished during 2011 and any subsequent year, to the extent that measures are available, the Secretary shall include quality measures on end of life care and advanced care planning that have been adopted or endorsed by a consensus-based organization, if appropriate. Such measures shall measure both the creation of and adherence to orders for life-sustaining treatment.

''(B) PROPOSED SET OF MEASURES.— The Secretary shall publish in the Federal Register proposed quality measures on end of life care and advanced care planning that the Secretary determines are described in subparagraph (A) and would be appropriate for eligible professionals to use to submit data to the Secretary. The Secretary shall provide for a period of pub-

lic comment on such set of measures before finalizing such proposed measures.''.

(c) INCLUSION OF INFORMATION IN MEDICARE & YOU HANDBOOK.—

(1) MEDICARE & YOU HANDBOOK.—

(A) IN GENERAL.—Not later than 1 year after the date of the enactment of this Act, the Secretary of Health and Human Services shall update the online version of the Medicare & You Handbook to include the following:

(i) An explanation of advance care planning and advance directives, including—

(I) living wills;

(II) durable power of attorney;

(III) orders of life-sustaining treatment; and

(IV) health care proxies.

(ii) A description of Federal and State resources available to assist individuals and their families with advance care planning and advance directives, including—

(I) available State legal service organizations to assist individuals with advance care planning, including

those organizations that receive funding pursuant to the Older Americans Act of 1965 (42 U.S.C. 93001 et seq.);

(II) website links or addresses for State-specific advance directive forms; and

(III) any additional information, as determined by the Secretary.

(B) UPDATE OF PAPER AND SUBSEQUENT VERSIONS.—The Secretary shall include the information described in subparagraph (A) in all paper and electronic versions of the Medicare & You Handbook that are published on or after the date that is 1 year after the date of the enactment of this Act.

SEC. 1234. PART B SPECIAL ENROLLMENT PERIOD AND WAIVER OF LIMITED ENROLLMENT PENALTY FOR TRICARE BENEFICIARIES.

(a) PART B SPECIAL ENROLLMENT PERIOD.—

(1) IN GENERAL.—Section 1837 of the Social Security Act (42 U.S.C. 1395p) is amended by adding at the end the following new subsection:

''(l)(1) In the case of any individual who is a covered beneficiary (as defined in section 1072(5) of title 10,

United States Code) at the time the individual is entitled to hospital insurance benefits under part A under section 226(b) or section 226A and who is eligible to enroll but who has elected not to enroll (or to be deemed enrolled) during the individual's initial enrollment period, there shall be a special enrollment period described in paragraph (2).

''(2) The special enrollment period described in this paragraph, with respect to an individual, is the 12-month period beginning on the day after the last day of the initial enrollment period of the individual or, if later, the 12-month period beginning with the month the individual is notified of enrollment under this section.

''(3) In the case of an individual who enrolls during the special enrollment period provided under paragraph (1), the coverage period under this part shall begin on the first day of the month in which the individual enrolls or, at the option of the individual, on the first day of the second month following the last month of the individual's initial enrollment period.

''(4) The Secretary of Defense shall establish a method for identifying individuals described in paragraph (1) and providing notice to them of their eligibility for enrollment during the special enrollment period described in paragraph (2).''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to elections made on or after the date of the enactment of this Act.

(b) WAIVER OF INCREASE OF PREMIUM.—

(1) IN GENERAL.—Section 1839(b) of the Social Security Act (42 U.S.C. 1395r(b)) is amended by striking ''section 1837(i)(4)'' and inserting ''subsection (i)(4) or (l) of section 1837''.

(2) EFFECTIVE DATE.—

(A) IN GENERAL.—The amendment made by paragraph (1) shall apply with respect to elections made on or after the date of the enactment of this Act.

(B) REBATES FOR CERTAIN DISABLED AND ESRD BENEFICIARIES.—

(i) IN GENERAL.—With respect to premiums for months on or after January 2005 and before the month of the enactment of this Act, no increase in the premium shall be effected for a month in the case of any individual who is a covered beneficiary (as defined in section 1072(5) of title 10, United States Code) at the time the individual is entitled to hospital insurance benefits under part A of title XVIII

of the Social Security Act under section 226(b) or 226A of such Act, and who is eligible to enroll, but who has elected not to enroll (or to be deemed enrolled), during the individual's initial enrollment period, and who enrolls under this part within the 12-month period that begins on the first day of the month after the month of notification of entitlement under this part.

(ii) CONSULTATION WITH DEPARTMENT OF DEFENSE.—The Secretary of Health and Human Services shall consult with the Secretary of Defense in identifying individuals described in this paragraph.

(iii) REBATES.—The Secretary of Health and Human Services shall establish a method for providing rebates of premium increases paid for months on or after January 1, 2005, and before the month of the enactment of this Act for which a penalty was applied and collected.

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.

(a) IN GENERAL.—Section 1839(i)(4)(C)(ii)(II) of the Social Security Act (42 U.S.C. 1395r(i)(4)(C)(ii)(II)) is amended by inserting ''sale of primary residence,'' after ''divorce of such individual,''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to premiums and payments for years beginning with 2011.

SEC. 1236. DEMONSTRATION PROGRAM ON USE OF PATIENT DECISIONS AIDS.

(a) IN GENERAL.—The Secretary of Health and Human Services shall establish a shared decision making demonstration program (in this subsection referred to as the ''program'') under the Medicare program using patient decision aids to meet the objective of improving the understanding by Medicare beneficiaries of their medical treatment options, as compared to comparable Medicare beneficiaries who do not participate in a shared decision making process using patient decision aids.

(b) SITES.—

(1) ENROLLMENT.—The Secretary shall enroll in the program not more than 30 eligible providers who have experience in implementing, and have in-

vested in the necessary infrastructure to implement, shared decision making using patient decision aids.

(2) APPLICATION.—An eligible provider seeking to participate in the program shall submit to the Secretary an application at such time and containing such information as the Secretary may require.

(3) PREFERENCE.—In enrolling eligible providers in the program, the Secretary shall give preference to eligible providers that—

(A) have documented experience in using patient decision aids for the conditions identified by the Secretary and in using shared decision making;

(B) have the necessary information technology infrastructure to collect the information required by the Secretary for reporting purposes; and

(C) are trained in how to use patient decision aids and shared decision making.

(c) FOLLOW-UP COUNSELING VISIT.—

(1) IN GENERAL.—An eligible provider participating in the program shall routinely schedule Medicare beneficiaries for a counseling visit after the viewing of such a patient decision aid to answer any questions the beneficiary may have with respect to

the medical care of the condition involved and to assist the beneficiary in thinking through how their preferences and concerns relate to their medical care.

(2) PAYMENT FOR FOLLOW-UP COUNSELING VISIT.—The Secretary shall establish procedures for making payments for such counseling visits provided to Medicare beneficiaries under the program. Such procedures shall provide for the establishment—

(A) of a code (or codes) to represent such services; and

(B) of a single payment amount for such service that includes the professional time of the health care provider and a portion of the reasonable costs of the infrastructure of the eligible provider such as would be made under the applicable payment systems to that provider for similar covered services.

(d) COSTS OF AIDS.—An eligible provider participating in the program shall be responsible for the costs of selecting, purchasing, and incorporating such patient decision aids into the provider's practice, and reporting data on quality and outcome measures under the program.

(e) FUNDING.—The Secretary shall provide for the transfer from the Federal Supplementary Medical Insur-

ance Trust Fund established under section 1841 of the Social Security Act (42 U.S.C. 1395t) of such funds as are necessary for the costs of carrying out the program.

(f) WAIVER AUTHORITY.—The Secretary may waive such requirements of titles XI and XVIII of the Social Security Act (42 U.S.C. 1301 et seq. and 1395 et seq.) as may be necessary for the purpose of carrying out the program.

(g) REPORT.—Not later than 12 months after the date of completion of the program, the Secretary shall submit to Congress a report on such program, together with recommendations for such legislation and administrative action as the Secretary determines to be appropriate. The final report shall include an evaluation of the impact of the use of the program on health quality, utilization of health care services, and on improving the quality of life of such beneficiaries.

(h) DEFINITIONS.—In this section:

(1) ELIGIBLE PROVIDER.—The term ''eligible provider'' means the following:

(A) A primary care practice.

(B) A specialty practice.

(C) A multispecialty group practice.

(D) A hospital.

(E) A rural health clinic.

(F) A Federally qualified health center (as defined in section 1861(aa)(4) of the Social Security Act (42 U.S.C. 1395x(aa)(4)).

(G) An integrated delivery system.

(H) A State cooperative entity that includes the State government and at least one other health care provider which is set up for the purpose of testing shared decision making and patient decision aids.

(2) PATIENT DECISION AID.—The term ''patient decision aid'' means an educational tool (such as the Internet, a video, or a pamphlet) that helps patients (or, if appropriate, the family caregiver of the patient) understand and communicate their beliefs and preferences related to their treatment options, and to decide with their health care provider what treatments are best for them based on their treatment options, scientific evidence, circumstances, beliefs, and preferences.

(3) SHARED DECISION MAKING.—The term ''shared decision making'' means a collaborative process between patient and clinician that engages the patient in decision making, provides patients with information about trade-offs among treatment

options, and facilitates the incorporation of patient preferences and values into the medical plan.

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

SEC. 1301. ACCOUNTABLE CARE ORGANIZATION PILOT PROGRAM.

Title XVIII of the Social Security Act is amended by inserting after section 1866C the following new section:

''ACCOUNTABLE CARE ORGANIZATION PILOT PROGRAM

''SEC. 1866D. (a) IN GENERAL.—The Secretary shall conduct a pilot program (in this section referred to as the 'pilot program') to test different payment incentive models, including (to the extent practicable) the specific payment incentive models described in subsection (c), designed to reduce the growth of expenditures and improve health outcomes in the provision of items and services under this title to applicable beneficiaries (as defined in subsection (d)) by qualifying accountable care organizations (as defined in subsection (b)(1)) in order to—

''(1) promote accountability for a patient population and coordinate items and services under parts A and B;

''(2) encourage investment in infrastructure and redesigned care processes for high quality and efficient service delivery; and

''(3) reward physician practices and other physician organizational models for the provision of high quality and efficient health care services.

''(b) QUALIFYING ACCOUNTABLE CARE ORGANIZATIONS (ACOS).—

''(1) QUALIFYING ACO DEFINED.—In this section:

''(A) IN GENERAL.—The terms 'qualifying accountable care organization' and 'qualifying ACO' mean a group of physicians or other physician organizational model (as defined in subparagraph (D)) that—

''(i) is organized at least in part for the purpose of providing physicians' services; and

''(ii) meets such criteria as the Secretary determines to be appropriate to participate in the pilot program, including the criteria specified in paragraph (2).

''(B) INCLUSION OF OTHER PROVIDERS.—Nothing in this subsection shall be construed as preventing a qualifying ACO from including a

hospital or any other provider of services or supplier furnishing items or services for which payment may be made under this title that is affiliated with the ACO under an arrangement structured so that such provider or supplier participates in the pilot program and shares in any incentive payments under the pilot program.

''(C) PHYSICIAN.—The term 'physician' includes, except as the Secretary may otherwise provide, any individual who furnishes services for which payment may be made as physicians' services.

''(D) OTHER PHYSICIAN ORGANIZATIONAL MODEL.—The term 'other physician organization model' means, with respect to a qualifying ACO any model of organization under which physicians enter into agreements with other providers for the purposes of participation in the pilot program in order to provide high quality and efficient health care services and share in any incentive payments under such program

''(E) OTHER SERVICES.—Nothing in this paragraph shall be construed as preventing a qualifying ACO from furnishing items or serv-

ices, for which payment may not be made under this title, for purposes of achieving performance goals under the pilot program.

''(2) QUALIFYING CRITERIA.—The following are criteria described in this paragraph for an organized group of physicians to be a qualifying ACO:

''(A) The group has a legal structure that would allow the group to receive and distribute incentive payments under this section.

''(B) The group includes a sufficient number of primary care physicians for the applicable beneficiaries for whose care the group is accountable (as determined by the Secretary).

''(C) The group reports on quality measures in such form, manner, and frequency as specified by the Secretary (which may be for the group, for providers of services and suppliers, or both).

''(D) The group reports to the Secretary (in a form, manner and frequency as specified by the Secretary) such data as the Secretary determines appropriate to monitor and evaluate the pilot program.

''(E) The group provides notice to applicable beneficiaries regarding the pilot program (as determined appropriate by the Secretary).

''(F) The group contributes to a best practices network or website, that shall be maintained by the Secretary for the purpose of sharing strategies on quality improvement, care coordination, and efficiency that the groups believe are effective.

''(G) The group utilizes patient-centered processes of care, including those that emphasize patient and caregiver involvement in planning and monitoring of ongoing care management plan.

''(H) The group meets other criteria determined to be appropriate by the Secretary.

''(c) SPECIFIC PAYMENT INCENTIVE MODELS.—The specific payment incentive models described in this subsection are the following:

''(1) PERFORMANCE TARGET MODEL.—Under the performance target model under this paragraph (in this paragraph referred to as the 'performance target model'):

''(A) IN GENERAL.—A qualifying ACO qualifies to receive an incentive payment if ex-

penditures for applicable beneficiaries are less than a target spending level or a target rate of growth. The incentive payment shall be made only if savings are greater than would result from normal variation in expenditures for items and services covered under parts A and B.

''(B) COMPUTATION OF PERFORMANCE TARGET.—

''(i) IN GENERAL.—The Secretary shall establish a performance target for each qualifying ACO comprised of a base amount (described in clause (ii)) increased to the current year by an adjustment factor (described in clause (iii)). Such a target may be established on a per capita basis, as the Secretary determines to be appropriate.

''(ii) BASE AMOUNT.—For purposes of clause (i), the base amount in this subparagraph is equal to the average total payments (or allowed charges) under parts A and B (and may include part D, if the Secretary determines appropriate) for applicable beneficiaries for whom the qualifying ACO furnishes items and services in

a base period determined by the Secretary. Such base amount may be determined on a per capita basis.

''(iii) ADJUSTMENT FACTOR.—For purposes of clause (i), the adjustment factor in this clause may equal an annual per capita amount that reflects changes in expenditures from the period of the base amount to the current year that would represent an appropriate performance target for applicable beneficiaries (as determined by the Secretary). Such adjustment factor may be determined as an amount or rate, may be determined on a national, regional, local, or organization-specific basis, and may be determined on a per capita basis. Such adjustment factor also may be adjusted for risk as determined appropriate by the Secretary.

''(iv) REBASING.—Under this model the Secretary shall periodically rebase the base expenditure amount described in clause (ii).

''(C) MEETING TARGET.—

''(i) IN GENERAL.—Subject to clause (ii), a qualifying ACO that meet or exceeds annual quality and performance targets for a year shall receive an incentive payment for such year equal to a portion (as determined appropriate by the Secretary) of the amount by which payments under this title for such year relative are estimated to be below the performance target for such year, as determined by the Secretary. The Secretary may establish a cap on incentive payments for a year for a qualifying ACO.

''(ii) LIMITATION.— The Secretary shall limit incentive payments to each qualifying ACO under this paragraph as necessary to ensure that the aggregate expenditures with respect to applicable beneficiaries for such ACOs under this title (inclusive of incentive payments described in this subparagraph) do not exceed the amount that the Secretary estimates would be expended for such ACO for such beneficiaries if the pilot program under this section were not implemented.

''(D) REPORTING AND OTHER REQUIREMENTS.—In carrying out such model, the Secretary may (as the Secretary determines to be appropriate) incorporate reporting requirements, incentive payments, and penalties related to the physician quality reporting initiative (PQRI), electronic prescribing, electronic health records, and other similar initiatives under section 1848, and may use alternative criteria than would otherwise apply under such section for determining whether to make such payments. The incentive payments described in this subparagraph shall not be included in the limit described in subparagraph (C)(ii) or in the performance target model described in this paragraph.

''(2) PARTIAL CAPITATION MODEL.—

''(A) IN GENERAL.—Subject to subparagraph (B), a partial capitation model described in this paragraph (in this paragraph referred to as a 'partial capitation model') is a model in which a qualifying ACO would be at financial risk for some, but not all, of the items and services covered under parts A and B, such as at risk for some or all physicians' services or all

items and services under part B. The Secretary may limit a partial capitation model to ACOs that are highly integrated systems of care and to ACOs capable of bearing risk, as determined to be appropriate by the Secretary.

''(B) NO ADDITIONAL PROGRAM EXPENDITURES.—Payments to a qualifying ACO for applicable beneficiaries for a year under the partial capitation model shall be established in a manner that does not result in spending more for such ACO for such beneficiaries than would otherwise be expended for such ACO for such beneficiaries for such year if the pilot program were not implemented, as estimated by the Secretary.

''(3) OTHER PAYMENT MODELS.—

''(A) IN GENERAL.—Subject to subparagraph (B), the Secretary may develop other payment models that meet the goals of this pilot program to improve quality and efficiency.

''(B) NO ADDITIONAL PROGRAM EXPENDITURES.—Subparagraph (B) of paragraph (2) shall apply to a payment model under subparagraph (A) in a similar manner as such subpara-

graph (B) applies to the payment model under paragraph (2).

''(d) APPLICABLE BENEFICIARIES.—

''(1) IN GENERAL.—In this section, the term 'applicable beneficiary' means, with respect to a qualifying ACO, an individual who—

''(A) is enrolled under part B and entitled to benefits under part A;

''(B) is not enrolled in a Medicare Advantage plan under part C or a PACE program under section 1894; and

''(C) meets such other criteria as the Secretary determines appropriate, which may include criteria relating to frequency of contact with physicians in the ACO

''(2) FOLLOWING APPLICABLE BENEFICIARIES.—The Secretary may monitor data on expenditures and quality of services under this title after an applicable beneficiary discontinues receiving services under this title through a qualifying ACO.

''(e) IMPLEMENTATION.—

''(1) STARTING DATE.—The pilot program shall begin no later than January 1, 2012. An agreement with a qualifying ACO under the pilot program may cover a multi-year period of between 3 and 5 years.

''(2) WAIVER.—The Secretary may waive such provisions of this title (including section 1877) and title XI in the manner the Secretary determines necessary in order implement the pilot program.

''(3) PERFORMANCE RESULTS REPORTS.—The Secretary shall report performance results to qualifying ACOs under the pilot program at least annually.

''(4) LIMITATIONS ON REVIEW.—There shall be no administrative or judicial review under section 1869, section 1878, or otherwise of—

''(A) the elements, parameters, scope, and duration of the pilot program;

''(B) the selection of qualifying ACOs for the pilot program;

''(C) the establishment of targets, measurement of performance, determinations with respect to whether savings have been achieved and the amount of savings;

''(D) determinations regarding whether, to whom, and in what amounts incentive payments are paid; and

''(E) decisions about the extension of the program under subsection (g), expansion of the

program under subsection (h) or extensions under subsection (i).

''(5) ADMINISTRATION.—Chapter 35 of title 44, United States Code shall not apply to this section.

''(f) EVALUATION; MONITORING.—

''(1) IN GENERAL.—The Secretary shall evaluate the payment incentive model for each qualifying ACO under the pilot program to assess impacts on beneficiaries, providers of services, suppliers and the program under this title. The Secretary shall make such evaluation publicly available within 60 days of the date of completion of such report.

''(2) MONITORING.—The Inspector General of the Department of Health and Human Services shall provide for monitoring of the operation of ACOs under the pilot program with regard to violations of section 1877 (popularly known as the 'Stark law').

''(g) EXTENSION OF PILOT AGREEMENT WITH SUCCESSFUL ORGANIZATIONS.—

''(1) REPORTS TO CONGRESS.—Not later than 2 years after the date the first agreement is entered into under this section, and biennially thereafter for six years, the Secretary shall submit to Congress and make publicly available a report on the use of authorities under the pilot program. Each report

shall address the impact of the use of those authorities on expenditures, access, and quality under this title.

''(2) EXTENSION.—Subject to the report provided under paragraph (1), with respect to a qualifying ACO, the Secretary may extend the duration of the agreement for such ACO under the pilot program as the Secretary determines appropriate if—

''(A) the ACO receives incentive payments with respect to any of the first 4 years of the pilot agreement and is consistently meeting quality standards or

''(B) the ACO is consistently exceeding quality standards and is not increasing spending under the program.

''(3) TERMINATION.—The Secretary may terminate an agreement with a qualifying ACO under the pilot program if such ACO did not receive incentive payments or consistently failed to meet quality standards in any of the first 3 years under the program.

''(h) EXPANSION TO ADDITIONAL ACOS.—

''(1) TESTING AND REFINEMENT OF PAYMENT INCENTIVE MODELS.—Subject to the evaluation described in subsection (f), the Secretary may enter

into agreements under the pilot program with additional qualifying ACOs to further test and refine payment incentive models with respect to qualifying ACOs.

''(2) EXPANDING USE OF SUCCESSFUL MODELS TO PROGRAM IMPLEMENTATION.—

''(A) IN GENERAL.—Subject to subparagraph (B), the Secretary may issue regulations to implement, on a permanent basis, 1 or more models if, and to the extent that, such models are beneficial to the program under this title, as determined by the Secretary.

''(B) CERTIFICATION.—The Chief Actuary of the Centers for Medicare & Medicaid Services shall certify that 1 or more of such models described in subparagraph (A) would result in estimated spending that would be less than what spending would otherwise be estimated to be in the absence of such expansion.

''(i) TREATMENT OF PHYSICIAN GROUP PRACTICE DEMONSTRATION.—

''(1) EXTENSION.—The Secretary may enter in to an agreement with a qualifying ACO under the demonstration under section 1866A, subject to rebasing and other modifications deemed appropriate

by the Secretary, until the pilot program under this section is operational.

''(2) TRANSITION.—For purposes of extension of an agreement with a qualifying ACO under subsection (g)(2), the Secretary shall treat receipt of an incentive payment for a year by an organization under the physician group practice demonstration pursuant to section 1866A as a year for which an incentive payment is made under such subsection, as long as such practice group practice organization meets the criteria under subsection (b)(2).

''(j) ADDITIONAL PROVISIONS.—

''(1) AUTHORITY FOR SEPARATE INCENTIVE ARRANGEMENTS.—The Secretary may create separate incentive arrangements (including using multiple years of data, varying thresholds, varying shared savings amounts, and varying shared savings limits) for different categories of qualifying ACOs to reflect natural variations in data availability, variation in average annual attributable expenditures, program integrity, and other matters the Secretary deems appropriate.

''(2) ENCOURAGEMENT OF PARTICIPATION OF SMALLER ORGANIZATIONS.—In order to encourage the participation of smaller accountable care organi-

zations under the pilot program, the Secretary may limit a qualifying ACO's exposure to high cost patients under the program.

''(3) INVOLVEMENT IN PRIVATE PAYER ARRANGEMENTS.—Nothing in this section shall be construed as preventing qualifying ACOs participating in the pilot program from negotiating similar contracts with private payers.

''(4) ANTIDISCRIMINATION LIMITATION.—The Secretary shall not enter into an agreement with an entity to provide health care items or services under the pilot program, or with an entity to administer the program, unless such entity guarantees that it will not deny, limit, or condition the coverage or provision of benefits under the program, for individuals eligible to be enrolled under such program, based on any health status-related factor described in section 2702(a)(1) of the Public Health Service Act.

''(5) CONSTRUCTION.—Nothing in this section shall be construed to compel or require an organization to use an organization-specific target growth rate for an accountable care organization under this section for purposes of section 1848.

''(6) FUNDING.—For purposes of administering and carrying out the pilot program, other than for

payments for items and services furnished under this title and incentive payments under subsection (c)(1), in addition to funds otherwise appropriated, there are appropriated to the Secretary for the Center for Medicare & Medicaid Services Program Management Account $25,000,000 for each of fiscal years 2010 through 2014 and $20,000,000 for fiscal year 2015. Amounts appropriated under this paragraph for a fiscal year shall be available until expended.''.

SEC. 1302. MEDICAL HOME PILOT PROGRAM.

(a) IN GENERAL.—Title XVIII of the Social Security Act is amended by inserting after section 1866D, as inserted by section 1301, the following new section:

''MEDICAL HOME PILOT PROGRAM

''SEC. 1866E. (a) ESTABLISHMENT AND MEDICAL HOME MODELS.—

''(1) ESTABLISHMENT OF PILOT PROGRAM.—The Secretary shall establish a medical home pilot program (in this section referred to as the 'pilot program') for the purpose of evaluating the feasibility and advisability of reimbursing qualified patient-centered medical homes for furnishing medical home services (as defined under subsection (b)(1)) to high need beneficiaries (as defined in subsection (d)(1)(C)) and to targeted high need beneficiaries (as defined in subsection (c)(1)(C)).

''(2) SCOPE.—Subject to subsection (g), the pilot program shall include urban, rural, and underserved areas.

''(3) MODELS OF MEDICAL HOMES IN THE PILOT PROGRAM.—The pilot program shall evaluate each of the following medical home models:

''(A) INDEPENDENT PATIENT-CENTERED MEDICAL HOME MODEL.—Independent patient-centered medical home model under subsection (c).

''(B) COMMUNITY-BASED MEDICAL HOME MODEL.—Community-based medical home model under subsection (d).

''(4) PARTICIPATION OF NURSE PRACTITIONERS AND PHYSICIAN ASSISTANTS.—

''(A) Nothing in this section shall be construed as preventing a nurse practitioner from leading a patient centered medical home so long as—

''(i) all the requirements of this section are met; and

''(ii) the nurse practitioner is acting consistently with State law.

''(B) Nothing in this section shall be construed as preventing a physician assistant from

participating in a patient centered medical home so long as—

''(i) all the requirements of this section are met; and

''(ii) the physician assistant is acting consistently with State law.

''(b) DEFINITIONS.—For purposes of this section:

''(1) PATIENT-CENTERED MEDICAL HOME SERVICES.—The term 'patient-centered medical home services' means services that—

''(A) provide beneficiaries with direct and ongoing access to a primary care or principal care by a physician or nurse practitioner who accepts responsibility for providing first contact, continuous and comprehensive care to such beneficiary;

''(B) coordinate the care provided to a beneficiary by a team of individuals at the practice level across office, institutional and home settings led by a primary care or principal care physician or nurse practitioner, as needed and appropriate;

''(C) provide for all the patient's health care needs or take responsibility for appro-

priately arranging care with other qualified providers for all stages of life;

''(D) provide continuous access to care and communication with participating beneficiaries;

''(E) provide support for patient self-management, proactive and regular patient monitoring, support for family caregivers, use patient-centered processes, and coordination with community resources;

''(F) integrate readily accessible, clinically useful information on participating patients that enables the practice to treat such patients comprehensively and systematically; and

''(G) implement evidence-based guidelines and apply such guidelines to the identified needs of beneficiaries over time and with the intensity needed by such beneficiaries.

''(2) PRIMARY CARE.—The term 'primary care' means health care that is provided by a physician or nurse practitioner who practices in the field of family medicine, general internal medicine, geriatric medicine, or pediatric medicine.

''(3) PRINCIPAL CARE.—The term 'principal care' means integrated, accessible health care that is provided by a physician who is a medical sub-

specialist that addresses the majority of the personal health care needs of patients with chronic conditions requiring the subspecialist's expertise, and for whom the subspecialist assumes care management.

''(c) INDEPENDENT PATIENT-CENTERED MEDICAL HOME MODEL.—

''(1) IN GENERAL.—

''(A) PAYMENT AUTHORITY.—Under the independent patient-centered medical home model under this subsection, the Secretary shall make payments for medical home services furnished by an independent patient-centered medical home (as defined in subparagraph (B)) pursuant to paragraph (3)(B) for a targeted high need beneficiaries (as defined in subparagraph (C)).

''(B) INDEPENDENT PATIENT-CENTERED MEDICAL HOME DEFINED.—In this section, the term 'independent patient-centered medical home' means a physician-directed or nurse-practitioner-directed practice that is qualified under paragraph (2) as—

''(i) providing beneficiaries with patient-centered medical home services; and

"(ii) meets such other requirements as the Secretary may specify.

"(C) TARGETED HIGH NEED BENEFICIARY DEFINED.—For purposes of this subsection, the term 'targeted high need beneficiary' means a high need beneficiary who, based on a risk score as specified by the Secretary, is generally within the upper 50th percentile of Medicare beneficiaries.

"(D) BENEFICIARY ELECTION TO PARTICIPATE.—The Secretary shall determine an appropriate method of ensuring that beneficiaries have agreed to participate in the pilot program.

"(E) IMPLEMENTATION.—The pilot program under this subsection shall begin no later than 6 months after the date of the enactment of this section.

"(2) STANDARD SETTING AND QUALIFICATION PROCESS FOR PATIENT-CENTERED MEDICAL HOMES.—The Secretary shall review alternative models for standard setting and qualification, and shall establish a process—

"(A) to establish standards to enable medical practices to qualify as patient-centered medical homes; and

''(B) to initially provide for the review and certification of medical practices as meeting such standards.

''(3) PAYMENT.—

''(A) ESTABLISHMENT OF METHODOLOGY.—The Secretary shall establish a methodology for the payment for medical home services furnished by independent patient-centered medical homes. Under such methodology, the Secretary shall adjust payments to medical homes based on beneficiary risk scores to ensure that higher payments are made for higher risk beneficiaries.

''(B) PER BENEFICIARY PER MONTH PAYMENTS.—Under such payment methodology, the Secretary shall pay independent patient-centered medical homes a monthly fee for each targeted high need beneficiary who consents to receive medical home services through such medical home.

''(C) PROSPECTIVE PAYMENT.—The fee under subparagraph (B) shall be paid on a prospective basis.

"(D) AMOUNT OF PAYMENT.—In determining the amount of such fee, the Secretary shall consider the following:

"(i) The clinical work and practice expenses involved in providing the medical home services provided by the independent patient-centered medical home (such as providing increased access, care coordination, population disease management, and teaching self-care skills for managing chronic illnesses) for which payment is not made under this title as of the date of the enactment of this section.

"(ii) Allow for differential payments based on capabilities of the independent patient-centered medical home.

"(iii) Use appropriate risk-adjustment in determining the amount of the per beneficiary per month payment under this paragraph in a manner that ensures that higher payments are made for higher risk beneficiaries.

"(4) ENCOURAGING PARTICIPATION OF VARIETY OF PRACTICES.—The pilot program under this subsection shall be designed to include the participa-

tion of physicians in practices with fewer than 10 full-time equivalent physicians, as well as physicians in larger practices, particularly in underserved and rural areas, as well as federally qualified community health centers, and rural health centers.

''(5) NO DUPLICATION IN PILOT PARTICIPATION.—A physician in a group practice that participates in the accountable care organization pilot program under section 1866D shall not be eligible to participate in the pilot program under this subsection, unless the pilot program under this section has been implemented on a permanent basis under subsection (e)(3).

''(d) COMMUNITY-BASED MEDICAL HOME MODEL.—

''(1) IN GENERAL.—

''(A) AUTHORITY FOR PAYMENTS.—Under the community-based medical home model under this subsection (in this section referred to as the 'CBMH model'), the Secretary shall make payments for the furnishing of medical home services by a community-based medical home (as defined in subparagraph (B)) pursuant to paragraph (5)(B) for high need beneficiaries.

''(B) COMMUNITY-BASED MEDICAL HOME DEFINED.—In this section, the term 'community-based medical home' means a nonprofit community-based or State-based organization that is certified under paragraph (2) as meeting the following requirements:

''(i) The organization provides beneficiaries with medical home services.

''(ii) The organization provides medical home services under the supervision of and in close collaboration with the primary care or principal care physician or nurse practitioner designated by the beneficiary as his or her community-based medical home provider.

''(iii) The organization employs community health workers, including nurses or other non-physician practitioners, lay health workers, or other persons as determined appropriate by the Secretary, that assist the primary or principal care physician or nurse practitioner in chronic care management activities such as teaching self-care skills for managing chronic illnesses, transitional care services, care plan

setting, medication therapy management services for patients with multiple chronic diseases, or help beneficiaries access the health care and community-based resources in their local geographic area.

''(iv) The organization meets such other requirements as the Secretary may specify.

''(C) HIGH NEED BENEFICIARY.—In this section, the term 'high need beneficiary' means an individual who requires regular medical monitoring, advising, or treatment.

''(2) QUALIFICATION PROCESS FOR COMMUNITY-BASED MEDICAL HOMES.—The Secretary shall establish a process—

''(A) for the initial qualification of community-based or State-based organizations as community-based medical homes; and

''(B) to provide for the review and qualification of such community-based and State-based organizations pursuant to criteria established by the Secretary.

''(3) DURATION.—The pilot program for community-based medical homes under this subsection shall start no later than 2 years after the date of the

enactment of this section. Each demonstration site under the pilot program shall operate for a period of up to 5 years after the initial implementation phase, without regard to the receipt of a initial implementation funding under subsection (i).

''(4) PREFERENCE.—In selecting sites for the CBMH model, the Secretary may give preference to—

''(A) applications from geographic areas that propose to coordinate health care services for chronically ill beneficiaries across a variety of health care settings, such as primary care physician practices with fewer than 10 physicians, specialty physicians, nurse practitioner practices, Federally qualified health centers, rural health clinics, and other settings;

''(B) applications that include other payors that furnish medical home services for chronically ill patients covered by such payors; and

''(C) applications from States that propose to use the medical home model to coordinate health care services for individuals enrolled under this title, individuals enrolled under title XIX, and full-benefit dual eligible individuals

(as defined in section 1935(c)(6)) with chronic diseases across a variety of health care settings.

''(5) PAYMENTS.—

''(A) ESTABLISHMENT OF METHODOLOGY.—The Secretary shall establish a methodology for the payment for medical home services furnished under the CBMH model.

''(B) PER BENEFICIARY PER MONTH PAYMENTS.—Under such payment methodology, the Secretary shall make two separate monthly payments for each high need beneficiary who consents to receive medical home services through such medical home, as follows:

''(i) PAYMENT TO COMMUNITY-BASED ORGANIZATION.—One monthly payment to a community-based or State-based organization.

''(ii) PAYMENT TO PRIMARY OR PRINCIPAL CARE PRACTICE.—One monthly payment to the primary or principal care practice for such beneficiary.

''(C) PROSPECTIVE PAYMENT.—The payments under subparagraph (B) shall be paid on a prospective basis.

"(D) AMOUNT OF PAYMENT.—In determining the amount of such payment, the Secretary shall consider the following:

"(i) The clinical work and practice expenses involved in providing the medical home services provided by the community-based medical home (such as providing increased access, care coordination, care plan setting, population disease management, and teaching self-care skills for managing chronic illnesses) for which payment is not made under this title as of the date of the enactment of this section.

"(ii) Use appropriate risk-adjustment in determining the amount of the per beneficiary per month payment under this paragraph.

"(6) INITIAL IMPLEMENTATION FUNDING.—The Secretary may make available initial implementation funding to a community based or State-based organization or a State that is participating in the pilot program under this subsection. Such organization shall provide the Secretary with a detailed implementation plan that includes how such funds will be used.

''(e) EXPANSION OF PROGRAM.—

''(1) EVALUATION OF COST AND QUALITY.—The Secretary shall evaluate the pilot program to determine—

''(A) the extent to which medical homes result in—

''(i) improvement in the quality and coordination of health care services, particularly with regard to the care of complex patients;

''(ii) improvement in reducing health disparities;

''(iii) reductions in preventable hospitalizations;

''(iv) prevention of readmissions;

''(v) reductions in emergency room visits;

''(vi) improvement in health outcomes, including patient functional status where applicable;

''(vii) improvement in patient satisfaction;

''(viii) improved efficiency of care such as reducing duplicative diagnostic tests and laboratory tests; and

''(ix) reductions in health care expenditures; and

''(B) the feasability and advisability of reimbursing medical homes for medical home services under this title on a permanent basis.

''(2) REPORT.—Not later than 60 days after the date of completion of the evaluation under paragraph (1), the Secretary shall submit to Congress and make available to the public a report on the findings of the evaluation under paragraph (1).

''(3) EXPANSION OF PROGRAM.—

''(A) IN GENERAL.—Subject to the results of the evaluation under paragraph (1) and subparagraph (B), the Secretary may issue regulations to implement, on a permanent basis, one or more models, if, and to the extent that such model or models, are beneficial to the program under this title, including that such implementation will improve quality of care, as determined by the Secretary.

''(B) CERTIFICATION REQUIREMENT.—The Secretary may not issue such regulations unless the Chief Actuary of the Centers for Medicare & Medicaid Services certifies that the expansion of the components of the pilot program de-

scribed in subparagraph (A) would result in estimated spending under this title that would be no more than the level of spending that the Secretary estimates would otherwise be spent under this title in the absence of such expansion.

''(f) ADMINISTRATIVE PROVISIONS.—

''(1) NO DUPLICATION IN PAYMENTS.—During any month, the Secretary may not make payments under this section under more than one model or through more than one medical home under any model for the furnishing of medical home services to an individual.

''(2) NO EFFECT ON PAYMENT FOR EVALUATION AND MANAGEMENT SERVICES.—Payments made under this section are in addition to, and have no effect on the amount of, payment for evaluation and management services made under this title

''(3) ADMINISTRATION.—Chapter 35 of title 44, United States Code shall not apply to this section.

''(g) FUNDING.—

''(1) OPERATIONAL COSTS.—For purposes of administering and carrying out the pilot program (including the design, implementation, technical assistance for and evaluation of such program), in ad-

dition to funds otherwise available, there shall be transferred from the Federal Supplementary Medical Insurance Trust Fund under section 1841 to the Secretary for the Centers for Medicare & Medicaid Services Program Management Account $6,000,000 for each of fiscal years 2010 through 2014. Amounts appropriated under this paragraph for a fiscal year shall be available until expended.

''(2) PATIENT-CENTERED MEDICAL HOME SERVICES.—In addition to funds otherwise available, there shall be available to the Secretary for the Centers for Medicare & Medicaid Services, from the Federal Supplementary Medical Insurance Trust Fund under section 1841—

''(A) $200,000,000 for each of fiscal years 2010 through 2014 for payments for medical home services under subsection (c)(3); and

''(B) $125,000,000 for each of fiscal years 2012 through 2016, for payments under subsection (d)(5).

Amounts available under this paragraph for a fiscal year shall be available until expended.

''(3) INITIAL IMPLEMENTATION.—In addition to funds otherwise available, there shall be available to the Secretary for the Centers for Medicare &

Medicaid Services, from the Federal Supplementary Medical Insurance Trust Fund under section 1841, $2,500,000 for each of fiscal years 2010 through 2012, under subsection (d)(6). Amounts available under this paragraph for a fiscal year shall be available until expended.

''(h) TREATMENT OF TRHCA MEDICARE MEDICAL HOME DEMONSTRATION FUNDING.—

''(1) In addition to funds otherwise available for payment of medical home services under subsection (c)(3), there shall also be available the amount provided in subsection (g) of section 204 of division B of the Tax Relief and Health Care Act of 2006 (42 U.S.C. 1395b–1 note).

''(2) Notwithstanding section 1302(c) of the America's Affordable Health Choices Act of 2009, in addition to funds provided in paragraph (1) and subsection (g)(2)(A), the funding for medical home services that would otherwise have been available if such section 204 medical home demonstration had been implemented (without regard to subsection (g) of such section) shall be available to the independent patient-centered medical home model described in subsection (c).''.

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to services furnished on or after the date of the enactment of this Act.

(c) CONFORMING REPEAL.—Section 204 of division B of the Tax Relief and Health Care Act of 2006 (42 U.S.C. 1395b–1 note), as amended by section 133(a)(2) of the Medicare Improvements for Patients and Providers Act of 2008 (Public Law 110–275), is repealed.

SEC. 1303. PAYMENT INCENTIVE FOR SELECTED PRIMARY CARE SERVICES.

(a) IN GENERAL.—Section 1833 of the Social Security Act is amended by inserting after subsection (o) the following new subsection:

''(p) PRIMARY CARE PAYMENT INCENTIVES.—

''(1) IN GENERAL.—In the case of primary care services (as defined in paragraph (2)) furnished on or after January 1, 2011, by a primary care practitioner (as defined in paragraph (3)) for which amounts are payable under section 1848, in addition to the amount otherwise paid under this part there shall also be paid to the practitioner (or to an employer or facility in the cases described in clause (A) of section 1842(b)(6)) (on a monthly or quarterly basis) from the Federal Supplementary Medical Insurance Trust Fund an amount equal 5 percent (or

10 percent if the practitioner predominately furnishes such services in an area that is designated (under section 332(a)(1)(A) of the Public Health Service Act) as a primary care health professional shortage area.

''(2) PRIMARY CARE SERVICES DEFINED.—In this subsection, the term 'primary care services'—

''(A) means services which are evaluation and management services as defined in section 1848(j)(5)(A); and

''(B) includes services furnished by another health care professional that would be described in subparagraph (A) if furnished by a physician.

''(3) PRIMARY CARE PRACTITIONER DEFINED.—In this subsection, the term 'primary care practitioner'—

''(A) means a physician or other health care practitioner (including a nurse practitioner) who—

''(i) specializes in family medicine, general internal medicine, general pediatrics, geriatrics, or obstetrics and gynecology; and

''(ii) has allowed charges for primary care services that account for at least 50 percent of the physician's or practitioner's total allowed charges under section 1848, as determined by the Secretary for the most recent period for which data are available; and

''(B) includes a physician assistant who is under the supervision of a practitioner described in subparagraph (A).

''(4) LIMITATION ON REVIEW.—There shall be no administrative or judicial review under section 1869, section 1878, or otherwise, respecting—

''(A) any determination or designation under this subsection;

''(B) the identification of services as primary care services under this subsection; and

''(C) the identification of a practitioner as a primary care practitioner under this subsection.

''(5) COORDINATION WITH OTHER PAYMENTS.—

''(A) WITH OTHER PRIMARY CARE INCENTIVES.—The provisions of this subsection shall not be taken into account in applying sub-

sections (m) and (u) and any payment under such subsections shall not be taken into account in computing payments under this subsection.

''(B) WITH QUALITY INCENTIVES.—Payments under this subsection shall not be taken into account in determining the amounts that would otherwise be paid under this part for purposes of section 1834(g)(2)(B).''.

(b) CONFORMING AMENDMENTS.—

(1) Section 1833 of such Act (42 U.S.C. 1395l(m)) is amended by redesignating paragraph (4) as paragraph (5) and by inserting after paragraph (3) the following new paragraph:

''(4) The provisions of this subsection shall not be taken into account in applying subsections (m) or (u) and any payment under such subsections shall not be taken into account in computing payments under this subsection.''.

(2) Section 1848(m)(5)(B) of such Act (42 U.S.C. 1395w–4(m)(5)(B)) is amended by inserting '', (p),'' after ''(m)''.

(3) Section 1848(o)(1)(B)(iv) of such Act (42 U.S.C. 1395w–4(o)(1)(B)(iv)) is amended by inserting ''primary care'' before ''health professional shortage area''.

SEC. 1304. INCREASED REIMBURSEMENT RATE FOR CERTIFIED NURSE-MIDWIVES.

(a) IN GENERAL.—Section 1833(a)(1)(K) of the Social Security Act (42 U.S.C.1395l(a)(1)(K)) is amended by striking ''(but in no event'' and all that follows through ''performed by a physician)''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to services furnished on or after January 1, 2011.

SEC. 1305. COVERAGE AND WAIVER OF COST-SHARING FOR PREVENTIVE SERVICES.

(a) MEDICARE COVERED PREVENTIVE SERVICES DEFINED.—Section 1861 of the Social Security Act (42 U.S.C. 1395x), as amended by section 1235(a)(2), is amended by adding at the end the following new subsection:

''Medicare Covered Preventive Services

''(iii)(1) Subject to the succeeding provisions of this subsection, the term 'Medicare covered preventive services' means the following:

''(A) Prostate cancer screening tests (as defined in subsection (oo)).

''(B) Colorectal cancer screening tests (as defined in subsection (pp) and when applicable as described in section 1305).

''(C) Diabetes outpatient self-management training services (as defined in subsection (qq)).

''(D) Screening for glaucoma for certain individuals (as described in subsection (s)(2)(U)).

''(E) Medical nutrition therapy services for certain individuals (as described in subsection (s)(2)(V)).

''(F) An initial preventive physical examination (as defined in subsection (ww)).

''(G) Cardiovascular screening blood tests (as defined in subsection (xx)(1)).

''(H) Diabetes screening tests (as defined in subsection (yy)).

''(I) Ultrasound screening for abdominal aortic aneurysm for certain individuals (as described in described in subsection (s)(2)(AA)).

''(J) Pneumococcal and influenza vaccines and their administration (as described in subsection (s)(10)(A)) and hepatitis B vaccine and its administration for certain individuals (as described in subsection (s)(10)(B)).

''(K) Screening mammography (as defined in subsection (jj)).

''(L) Screening pap smear and screening pelvic exam (as defined in subsection (nn)).

''(M) Bone mass measurement (as defined in subsection (rr)).

''(N) Kidney disease education services (as defined in subsection (ggg)).

''(O) Additional preventive services (as defined in subsection (ddd)).

''(2) With respect to specific Medicare covered preventive services, the limitations and conditions described in the provisions referenced in paragraph (1) with respect to such services shall apply.''.

(b) PAYMENT AND ELIMINATION OF COST-SHARING.—

(1) IN GENERAL.—

(A) IN GENERAL.—Section 1833(a) of the Social Security Act (42 U.S.C. 1395l(a)) is amended by adding after and below paragraph (9) the following:

''With respect to Medicare covered preventive services, in any case in which the payment rate otherwise provided under this part is computed as a percent of less than 100 percent of an actual charge, fee schedule rate, or other rate, such percentage shall be increased to 100 percent.''.

(B) APPLICATION TO SIGMOIDOSCOPIES AND COLONOSCOPIES.—Section 1834(d) of such Act (42 U.S.C. 1395m(d)) is amended—

(i) in paragraph (2)(C), by amending clause (ii) to read as follows:

''(ii) NO COINSURANCE.—In the case of a beneficiary who receives services described in clause (i), there shall be no coinsurance applied.''; and

(ii) in paragraph (3)(C), by amending clause (ii) to read as follows:

''(ii) NO COINSURANCE.—In the case of a beneficiary who receives services described in clause (i), there shall be no coinsurance applied.''.

(2) ELIMINATION OF COINSURANCE IN OUTPATIENT HOSPITAL SETTINGS.—

(A) EXCLUSION FROM OPD FEE SCHEDULE.—Section 1833(t)(1)(B)(iv) of the Social Security Act (42 U.S.C. 1395l(t)(1)(B)(iv)) is amended by striking ''screening mammography (as defined in section 1861(jj)) and diagnostic mammography'' and inserting ''diagnostic mammograms and Medicare covered preventive services (as defined in section 1861(iii)(1))''.

(B) CONFORMING AMENDMENTS.—Section 1833(a)(2) of the Social Security Act (42 U.S.C. 1395l(a)(2)) is amended—

(i) in subparagraph (F), by striking ''and'' after the semicolon at the end;

(ii) in subparagraph (G)(ii), by adding ''and'' at the end; and

(iii) by adding at the end the following new subparagraph:

''(H) with respect to additional preventive services (as defined in section 1861(ddd)) furnished by an outpatient department of a hospital, the amount determined under paragraph (1)(W);''.

(3) WAIVER OF APPLICATION OF DEDUCTIBLE FOR ALL PREVENTIVE SERVICES.—The first sentence of section 1833(b) of the Social Security Act (42 U.S.C. 1395l(b)) is amended—

(A) in clause (1), by striking ''items and services described in section 1861(s)(10)(A)'' and inserting ''Medicare covered preventive services (as defined in section 1861(iii))'';

(B) by inserting ''and'' before ''(4)''; and

(C) by striking clauses (5) through (8).

(4) APPLICATION TO PROVIDERS OF SERVICES.—Section 1866(a)(2)(A)(ii) of such Act (42 U.S.C. 1395cc(a)(2)(A)(ii)) is amended by inserting

''other than for Medicare covered preventive services and'' after ''for such items and services (''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after January 1, 2011.

SEC. 1306. WAIVER OF DEDUCTIBLE FOR COLORECTAL CANCER SCREENING TESTS REGARDLESS OF CODING, SUBSEQUENT DIAGNOSIS, OR ANCILLARY TISSUE REMOVAL.

(a) IN GENERAL.—Section 1833(b) of the Social Security Act (42 U.S.C. 1395l(b)), as amended by section 1305(b)(3), is amended by adding at the end the following new sentence: ''Clause (1) of the first sentence of this subsection shall apply with respect to a colorectal cancer screening test regardless of the code that is billed for the establishment of a diagnosis as a result of the test, or for the removal of tissue or other matter or other procedure that is furnished in connection with, as a result of, and in the same clinical encounter as, the screening test.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to items and services furnished on or after January 1, 2011.

SEC. 1307. EXCLUDING CLINICAL SOCIAL WORKER SERVICES FROM COVERAGE UNDER THE MEDICARE SKILLED NURSING FACILITY PROSPECTIVE PAYMENT SYSTEM AND CONSOLIDATED PAYMENT.

(a) IN GENERAL.—Section 1888(e)(2)(A)(ii) of the Social Security Act (42 U.S.C. 1395yy(e)(2)(A)(ii)) is amended by inserting ''clinical social worker services,'' after ''qualified psychologist services,''.

(b) CONFORMING AMENDMENT.—Section 1861(hh)(2) of the Social Security Act (42 U.S.C. 1395x(hh)(2)) is amended by striking ''and other than services furnished to an inpatient of a skilled nursing facility which the facility is required to provide as a requirement for participation''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to items and services furnished on or after July 1, 2010.

SEC. 1308. COVERAGE OF MARRIAGE AND FAMILY THERAPIST SERVICES AND MENTAL HEALTH COUNSELOR SERVICES.

(a) COVERAGE OF MARRIAGE AND FAMILY THERAPIST SERVICES.—

(1) COVERAGE OF SERVICES.—Section 1861(s)(2) of the Social Security Act (42 U.S.C.

1395x(s)(2)), as amended by section 1235, is amended—

(A) in subparagraph (EE), by striking ''and'' at the end;

(B) in subparagraph (FF), by adding ''and'' at the end; and

(C) by adding at the end the following new subparagraph:

''(GG) marriage and family therapist services (as defined in subsection (jjj));''.

(2) DEFINITION.—Section 1861 of the Social Security Act (42 U.S.C. 1395x), as amended by sections 1235 and 1305, is amended by adding at the end the following new subsection:

''Marriage and Family Therapist Services

''(jjj)(1) The term 'marriage and family therapist services' means services performed by a marriage and family therapist (as defined in paragraph (2)) for the diagnosis and treatment of mental illnesses, which the marriage and family therapist is legally authorized to perform under State law (or the State regulatory mechanism provided by State law) of the State in which such services are performed, as would otherwise be covered if furnished by a physician or as incident to a physician's professional service, but only if no facility or other provider charges

or is paid any amounts with respect to the furnishing of such services.

''(2) The term 'marriage and family therapist' means an individual who—

''(A) possesses a master's or doctoral degree which qualifies for licensure or certification as a marriage and family therapist pursuant to State law;

''(B) after obtaining such degree has performed at least 2 years of clinical supervised experience in marriage and family therapy; and

''(C) is licensed or certified as a marriage and family therapist in the State in which marriage and family therapist services are performed.''.

(3) PROVISION FOR PAYMENT UNDER PART B.—Section 1832(a)(2)(B) of the Social Security Act (42 U.S.C. 1395k(a)(2)(B)) is amended by adding at the end the following new clause:

''(v) marriage and family therapist services;''.

(4) AMOUNT OF PAYMENT.—

(A) IN GENERAL.—Section 1833(a)(1) of the Social Security Act (42 U.S.C. 1395l(a)(1)) is amended—

(i) by striking ''and'' before ''(W)''; and

(ii) by inserting before the semicolon at the end the following: '', and (X) with respect to marriage and family therapist services under section 1861(s)(2)(GG), the amounts paid shall be 80 percent of the lesser of the actual charge for the services or 75 percent of the amount determined for payment of a psychologist under clause (L)''.

(B) DEVELOPMENT OF CRITERIA WITH RESPECT TO CONSULTATION WITH A HEALTH CARE PROFESSIONAL.—The Secretary of Health and Human Services shall, taking into consideration concerns for patient confidentiality, develop criteria with respect to payment for marriage and family therapist services for which payment may be made directly to the marriage and family therapist under part B of title XVIII of the Social Security Act (42 U.S.C. 1395j et seq.) under which such a therapist must agree to consult with a patient's attending or primary care physician or nurse practitioner in accordance with such criteria.

(5) EXCLUSION OF MARRIAGE AND FAMILY THERAPIST SERVICES FROM SKILLED NURSING FACILITY PROSPECTIVE PAYMENT SYSTEM.—Section 1888(e)(2)(A)(ii) of the Social Security Act (42 U.S.C. 1395yy(e)(2)(A)(ii)), as amended by section 1307(a), is amended by inserting ''marriage and family therapist services (as defined in subsection (jjj)(1)),'' after ''clinical social worker services,''.

(6) COVERAGE OF MARRIAGE AND FAMILY THERAPIST SERVICES PROVIDED IN RURAL HEALTH CLINICS AND FEDERALLY QUALIFIED HEALTH CENTERS.—Section 1861(aa)(1)(B) of the Social Security Act (42 U.S.C. 1395x(aa)(1)(B)) is amended by striking ''or by a clinical social worker (as defined in subsection (hh)(1)),'' and inserting '', by a clinical social worker (as defined in subsection (hh)(1)), or by a marriage and family therapist (as defined in subsection (jjj)(2)),''.

(7) INCLUSION OF MARRIAGE AND FAMILY THERAPISTS AS PRACTITIONERS FOR ASSIGNMENT OF CLAIMS.—Section 1842(b)(18)(C) of the Social Security Act (42 U.S.C. 1395u(b)(18)(C)) is amended by adding at the end the following new clause:

''(vii) A marriage and family therapist (as defined in section 1861(jjj)(2)).''.

(b) COVERAGE OF MENTAL HEALTH COUNSELOR SERVICES.—

(1) COVERAGE OF SERVICES.—Section 1861(s)(2) of the Social Security Act (42 U.S.C. 1395x(s)(2)), as previously amended, is further amended—

(A) in subparagraph (FF), by striking ''and'' at the end;

(B) in subparagraph (GG), by inserting ''and'' at the end; and

(C) by adding at the end the following new subparagraph:

''(HH) mental health counselor services (as defined in subsection (kkk)(1));''.

(2) DEFINITION.—Section 1861 of the Social Security Act (42 U.S.C. 1395x), as previously amended, is amended by adding at the end the following new subsection:

''Mental Health Counselor Services

''(kkk)(1) The term 'mental health counselor services' means services performed by a mental health counselor (as defined in paragraph (2)) for the diagnosis and treatment of mental illnesses which the mental health counselor is legally authorized to perform under State law (or the State regulatory mechanism provided by the State law) of

the State in which such services are performed, as would otherwise be covered if furnished by a physician or as incident to a physician's professional service, but only if no facility or other provider charges or is paid any amounts with respect to the furnishing of such services.

''(2) The term 'mental health counselor' means an individual who—

''(A) possesses a master's or doctor's degree which qualifies the individual for licensure or certification for the practice of mental health counseling in the State in which the services are performed;

''(B) after obtaining such a degree has performed at least 2 years of supervised mental health counselor practice; and

''(C) is licensed or certified as a mental health counselor or professional counselor by the State in which the services are performed.''.

(3) PROVISION FOR PAYMENT UNDER PART B.—Section 1832(a)(2)(B) of the Social Security Act (42 U.S.C. 1395k(a)(2)(B)), as amended by subsection (a)(3), is further amended—

(A) by striking ''and'' at the end of clause (iv);

(B) by adding ''and'' at the end of clause (v); and

(C) by adding at the end the following new clause:

''(vi) mental health counselor services;''.

(4) AMOUNT OF PAYMENT.—

(A) IN GENERAL.—Section 1833(a)(1) of the Social Security Act (42 U.S.C. 1395l(a)(1)), as amended by subsection (a), is further amended—

(i) by striking ''and''before ''(X)''; and

(ii) by inserting before the semicolon at the end the following: '', and (Y), with respect to mental health counselor services under section 1861(s)(2)(HH), the amounts paid shall be 80 percent of the lesser of the actual charge for the services or 75 percent of the amount determined for payment of a psychologist under clause (L)''.

(B) DEVELOPMENT OF CRITERIA WITH RESPECT TO CONSULTATION WITH A PHYSICIAN.—The Secretary of Health and Human Services shall, taking into consideration concerns for patient confidentiality, develop criteria with re-

spect to payment for mental health counselor services for which payment may be made directly to the mental health counselor under part B of title XVIII of the Social Security Act (42 U.S.C. 1395j et seq.) under which such a counselor must agree to consult with a patient's attending or primary care physician in accordance with such criteria.

(5) EXCLUSION OF MENTAL HEALTH COUNSELOR SERVICES FROM SKILLED NURSING FACILITY PROSPECTIVE PAYMENT SYSTEM.—Section 1888(e)(2)(A)(ii) of the Social Security Act (42 U.S.C. 1395yy(e)(2)(A)(ii)), as amended by section 1307(a) and subsection (a), is amended by inserting ''mental health counselor services (as defined in section 1861(kkk)(1)),'' after ''marriage and family therapist services (as defined in subsection (jjj)(1)),''.

(6) COVERAGE OF MENTAL HEALTH COUNSELOR SERVICES PROVIDED IN RURAL HEALTH CLINICS AND FEDERALLY QUALIFIED HEALTH CENTERS.—Section 1861(aa)(1)(B) of the Social Security Act (42 U.S.C. 1395x(aa)(1)(B)), as amended by subsection (a), is amended by striking ''or by a marriage and family therapist (as defined in sub-

section (jjj)(2)),'' and inserting ''by a marriage and family therapist (as defined in subsection (jjj)(2)), or a mental health counselor (as defined in subsection (kkk)(2)),''.

(7) INCLUSION OF MENTAL HEALTH COUNSELORS AS PRACTITIONERS FOR ASSIGNMENT OF CLAIMS.—Section 1842(b)(18)(C) of the Social Security Act (42 U.S.C. 1395u(b)(18)(C)), as amended by subsection (a)(7), is amended by adding at the end the following new clause:

''(viii) A mental health counselor (as defined in section 1861(kkk)(2)).''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to items and services furnished on or after January 1, 2011.

SEC. 1309. EXTENSION OF PHYSICIAN FEE SCHEDULE MENTAL HEALTH ADD-ON.

Section 138(a)(1) of the Medicare Improvements for Patients and Providers Act of 2008 (Public Law 110–275) is amended by striking ''December 31, 2009'' and inserting ''December 31, 2011''.

SEC. 1310. EXPANDING ACCESS TO VACCINES.

(a) IN GENERAL.—Paragraph (10) of section 1861(s) of the Social Security Act (42 U.S.C. 1395w(s)) is amended to read as follows:

''(10) federally recommended vaccines (as defined in subsection (lll)) and their respective administration;''.

(b) FEDERALLY RECOMMENDED VACCINES DEFINED.—Section 1861 of such Act is further amended by adding at the end the following new subsection:

''Federally Recommended Vaccines

''(lll) The term 'federally recommended vaccine' means an approved vaccine recommended by the Advisory Committee on Immunization Practices (an advisory committee established by the Secretary, acting through the Director of the Centers for Disease Control and Prevention).''.

(c) CONFORMING AMENDMENTS.—

(1) Section 1833 of such Act (42 U.S.C. 1395l) is amended, in each of subsections (a)(1)(B), (a)(2)(G), (a)(3)(A), and (b)(1) (as amended by section 1305(b)), by striking ''1861(s)(10)(A)'' or ''1861(s)(10)(B)'' and inserting ''1861(s)(10)'' each place it appears.

(2) Section 1842(o)(1)(A)(iv) of such Act (42 U.S.C. 1395u(o)(1)(A)(iv)) is amended—

(A) by striking ''subparagraph (A) or (B) of''; and

(B) by inserting before the period the following: ''and before January 1, 2011, and influenza vaccines furnished on or after January 1, 2011''.

(3) Section 1847A(c)(6) of such Act (42 U.S.C. 1395w–3a(c)(6)) is amended by striking subparagraph (G) and inserting the following:

''(G) IMPLEMENTATION.—Chapter 35 of title 44, United States Code shall not apply to manufacturer provision of information pursuant to section 1927(b)(3)(A)(iii) for purposes of implementation of this section.''.

(4) Section 1860D–2(e)(1)(B) of such Act (42 U.S.C. 1395w–102(e)(1)(B)) is amended by striking ''such term includes a vaccine'' and all that follows through ''its administration) and''.

(5) Section 1861(ww)(2)(A) of such Act (42 U.S.C. 1395x(ww)(2)(A))) is amended by striking ''Pneumococcal, influenza, and hepatitis B and administration'' and inserting ''Federally recommended vaccines (as defined in subsection (lll)) and their respective administration''.

(6) Section 1861(iii)(1) of such Act, as added by section 1305(a), is amended by amending subparagraph (J) to read as follows:

''(J) Federally recommended vaccines (as defined in subsection (lll)) and their respective administration.''.

(7) Section 1927(b)(3)(A)(iii) of such Act (42 U.S.C. 1396r–8(b)(3)(A)(iii)) is amended, in the matter following subclause (III), by inserting ''(A)(iv) (including influenza vaccines furnished on or after January 1, 2011),'' after ''described in subparagraph.''

(d) EFFECTIVE DATES.—The amendments made by—

(1) this section (other than by subsection (c)(7)) shall apply to vaccines administered on or after January 1, 2011; and

(2) by subsection (c)(7) shall apply to calendar quarters beginning on or after January 1, 2010.

TITLE IV—QUALITY

Subtitle A—Comparative Effectiveness Research

SEC. 1401. COMPARATIVE EFFECTIVENESS RESEARCH.

(a) IN GENERAL.—title XI of the Social Security Act is amended by adding at the end the following new part:

''PART D—COMPARATIVE EFFECTIVENESS RESEARCH

''comparative effectiveness research

''SEC. 1181. (a) CENTER FOR COMPARATIVE EFFECTIVENESS RESEARCH ESTABLISHED.—

''(1) IN GENERAL.—The Secretary shall establish within the Agency for Healthcare Research and Quality a Center for Comparative Effectiveness Research (in this section referred to as the 'Center') to conduct, support, and synthesize research (including research conducted or supported under section 1013 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003) with respect to the outcomes, effectiveness, and appropriateness of health care services and procedures in order to identify the manner in which diseases, disorders, and other health conditions can most effectively and appropriately be prevented, diagnosed, treated, and managed clinically.

''(2) DUTIES.—The Center shall—

''(A) conduct, support, and synthesize research relevant to the comparative effectiveness of the full spectrum of health care items, services and systems, including pharmaceuticals, medical devices, medical and surgical procedures, and other medical interventions;

''(B) conduct and support systematic reviews of clinical research, including original research conducted subsequent to the date of the enactment of this section;

''(C) continuously develop rigorous scientific methodologies for conducting comparative effectiveness studies, and use such methodologies appropriately;

''(D) submit to the Comparative Effectiveness Research Commission, the Secretary, and Congress appropriate relevant reports described in subsection (d)(2); and

''(E) encourage, as appropriate, the development and use of clinical registries and the development of clinical effectiveness research data networks from electronic health records, post marketing drug and medical device surveillance efforts, and other forms of electronic health data.

''(3) POWERS.—

''(A) OBTAINING OFFICIAL DATA.—The Center may secure directly from any department or agency of the United States information necessary to enable it to carry out this section. Upon request of the Center, the head of

that department or agency shall furnish that information to the Center on an agreed upon schedule.

''(B) DATA COLLECTION.—In order to carry out its functions, the Center shall—

''(i) utilize existing information, both published and unpublished, where possible, collected and assessed either by its own staff or under other arrangements made in accordance with this section,

''(ii) carry out, or award grants or contracts for, original research and experimentation, where existing information is inadequate, and

''(iii) adopt procedures allowing any interested party to submit information for the use by the Center and Commission under subsection (b) in making reports and recommendations.

''(C) ACCESS OF GAO TO INFORMATION.—The Comptroller General shall have unrestricted access to all deliberations, records, and nonproprietary data of the Center and Commission under subsection (b), immediately upon request.

''(D) PERIODIC AUDIT.—The Center and Commission under subsection (b) shall be subject to periodic audit by the Comptroller General.

''(b) OVERSIGHT BY COMPARATIVE EFFECTIVENESS RESEARCH COMMISSION.—

''(1) IN GENERAL.—The Secretary shall establish an independent Comparative Effectiveness Research Commission (in this section referred to as the 'Commission') to oversee and evaluate the activities carried out by the Center under subsection (a), subject to the authority of the Secretary, to ensure such activities result in highly credible research and information resulting from such research.

''(2) DUTIES.—The Commission shall—

''(A) determine national priorities for research described in subsection (a) and in making such determinations consult with a broad array of public and private stakeholders, including patients and health care providers and payers;

''(B) monitor the appropriateness of use of the CERTF described in subsection (g) with respect to the timely production of comparative

effectiveness research determined to be a national priority under subparagraph (A);

''(C) identify highly credible research methods and standards of evidence for such research to be considered by the Center;

''(D) review the methodologies developed by the center under subsection (a)(2)(C);

''(E) not later than one year after the date of the enactment of this section, enter into an arrangement under which the Institute of Medicine of the National Academy of Sciences shall conduct an evaluation and report on standards of evidence for such research;

''(F) support forums to increase stakeholder awareness and permit stakeholder feedback on the efforts of the Center to advance methods and standards that promote highly credible research;

''(G) make recommendations for policies that would allow for public access of data produced under this section, in accordance with appropriate privacy and proprietary practices, while ensuring that the information produced through such data is timely and credible;

''(H) appoint a clinical perspective advisory panel for each research priority determined under subparagraph (A), which shall consult with patients and advise the Center on research questions, methods, and evidence gaps in terms of clinical outcomes for the specific research inquiry to be examined with respect to such priority to ensure that the information produced from such research is clinically relevant to decisions made by clinicians and patients at the point of care;

''(I) make recommendations for the priority for periodic reviews of previous comparative effectiveness research and studies conducted by the Center under subsection (a);

''(J) routinely review processes of the Center with respect to such research to confirm that the information produced by such research is objective, credible, consistent with standards of evidence established under this section, and developed through a transparent process that includes consultations with appropriate stakeholders; and

''(K) make recommendations to the center for the broad dissemination of the findings of

research conducted and supported under this section that enables clinicians, patients, consumers, and payers to make more informed health care decisions that improve quality and value.

''(3) COMPOSITION OF COMMISSION.—

''(A) IN GENERAL.—The members of the Commission shall consist of—

''(i) the Director of the Agency for Healthcare Research and Quality;

''(ii) the Chief Medical Officer of the Centers for Medicare & Medicaid Services; and

''(iii) 15 additional members who shall represent broad constituencies of stakeholders including clinicians, patients, researchers, third-party payers, consumers of Federal and State beneficiary programs.

Of such members, at least 9 shall be practicing physicians, health care practitioners, consumers, or patients.

''(B) QUALIFICATIONS.—

''(i) DIVERSE REPRESENTATION OF PERSPECTIVES.—The members of the Commission shall represent a broad range

of perspectives and shall collectively have experience in the following areas:

''(I) Epidemiology.

''(II) Health services research.

''(III) Bioethics.

''(IV) Decision sciences.

''(V) Health disparities.

''(VI) Economics.

''(ii) DIVERSE REPRESENTATION OF HEALTH CARE COMMUNITY.—At least one member shall represent each of the following health care communities:

''(I) Patients.

''(II) Health care consumers.

''(III) Practicing Physicians, including surgeons.

''(IV) Other health care practitioners engaged in clinical care.

''(V) Employers.

''(VI) Public payers.

''(VII) Insurance plans.

''(VIII) Clinical researchers who conduct research on behalf of pharmaceutical or device manufacturers.

"(C) LIMITATION.—No more than 3 of the Members of the Commission may be representatives of pharmaceutical or device manufacturers and such representatives shall be clinical researchers described under subparagraph (B)(ii)(VIII).

"(4) APPOINTMENT.—

"(A) IN GENERAL.—The Secretary shall appoint the members of the Commission.

"(B) CONSULTATION.—In considering candidates for appointment to the Commission, the Secretary may consult with the Government Accountability Office and the Institute of Medicine of the National Academy of Sciences.

"(5) CHAIRMAN; VICE CHAIRMAN.—The Secretary shall designate a member of the Commission, at the time of appointment of the member, as Chairman and a member as Vice Chairman for that term of appointment, except that in the case of vacancy of the Chairmanship or Vice Chairmanship, the Secretary may designate another member for the remainder of that member's term. The Chairman shall serve as an ex officio member of the National Advisory Council of the Agency for Health Care Re-

search and Quality under section 931(c)(3)(B) of the Public Health Service Act.

''(6) TERMS.—

''(A) IN GENERAL.—Except as provided in subparagraph (B), each member of the Commission shall be appointed for a term of 4 years.

''(B) TERMS OF INITIAL APPOINTEES.—Of the members first appointed—

''(i) 8 shall be appointed for a term of 4 years; and

''(ii) 7 shall be appointed for a term of 3 years.

''(7) COORDINATION.—To enhance effectiveness and coordination, the Secretary is encouraged, to the greatest extent possible, to seek coordination between the Commission and the National Advisory Council of the Agency for Healthcare Research and Quality.

''(8) CONFLICTS OF INTEREST.—

''(A) IN GENERAL.—In appointing the members of the Commission or a clinical perspective advisory panel described in paragraph (2)(H), the Secretary or the Commission, respectively, shall take into consideration any fi-

nancial interest (as defined in subparagraph (D)), consistent with this paragraph, and develop a plan for managing any identified conflicts.

''(B) EVALUATION AND CRITERIA.—When considering an appointment to the Commission or a clinical perspective advisory panel described paragraph (2)(H) the Secretary or the Commission shall review the expertise of the individual and the financial disclosure report filed by the individual pursuant to the Ethics in Government Act of 1978 for each individual under consideration for the appointment, so as to reduce the likelihood that an appointed individual will later require a written determination as referred to in section 208(b)(1) of title 18, United States Code, a written certification as referred to in section 208(b)(3) of title 18, United States Code, or a waiver as referred to in subparagraph (D)(iii) for service on the Commission at a meeting of the Commission.

''(C) DISCLOSURES; PROHIBITIONS ON PARTICIPATION; WAIVERS.—

''(i) DISCLOSURE OF FINANCIAL INTEREST.—Prior to a meeting of the Com-

mission or a clinical perspective advisory panel described in paragraph (2)(H) regarding a 'particular matter' (as that term is used in section 208 of title 18, United States Code), each member of the Commission or the clinical perspective advisory panel who is a full-time Government employee or special Government employee shall disclose to the Secretary financial interests in accordance with subsection (b) of such section 208.

''(ii) PROHIBITIONS ON PARTICIPATION.—Except as provided under clause (iii), a member of the Commission or a clinical perspective advisory panel described in paragraph (2)(H) may not participate with respect to a particular matter considered in meeting of the Commission or the clinical perspective advisory panel if such member (or an immediate family member of such member) has a financial interest that could be affected by the advice given to the Secretary with respect to such matter, excluding interests exempted in regulations issued by the Director of the

Office of Government Ethics as too remote or inconsequential to affect the integrity of the services of the Government officers or employees to which such regulations apply.

''(iii) WAIVER.—If the Secretary determines it necessary to afford the Commission or a clinical perspective advisory panel described in paragraph 2(H) essential expertise, the Secretary may grant a waiver of the prohibition in clause (ii) to permit a member described in such subparagraph to—

''(I) participate as a non-voting member with respect to a particular matter considered in a Commission or a clinical perspective advisory panel meeting; or

''(II) participate as a voting member with respect to a particular matter considered in a Commission or a clinical perspective advisory panel meeting.

''(iv) LIMITATION ON WAIVERS AND OTHER EXCEPTIONS.—

''(I) DETERMINATION OF ALLOWABLE EXCEPTIONS FOR THE COMMISSION.—The number of waivers granted to members of the Commission cannot exceed one-half of the total number of members for the Commission.

''(II) PROHIBITION ON VOTING STATUS ON CLINICAL PERSPECTIVE ADVISORY PANELS.—No voting member of any clinical perspective advisory panel shall be in receipt of a waiver. No more than two nonvoting members of any clinical perspective advisory panel shall receive a waiver.

''(D) FINANCIAL INTEREST DEFINED.—For purposes of this paragraph, the term 'financial interest' means a financial interest under section 208(a) of title 18, United States Code.

''(9) COMPENSATION.—While serving on the business of the Commission (including travel time), a member of the Commission shall be entitled to compensation at the per diem equivalent of the rate provided for level IV of the Executive Schedule

under section 5315 of title 5, United States Code; and while so serving away from home and the member's regular place of business, a member may be allowed travel expenses, as authorized by the Director of the Commission.

''(10) AVAILABILITY OF REPORTS.—The Commission shall transmit to the Secretary a copy of each report submitted under this subsection and shall make such reports available to the public.

''(11) DIRECTOR AND STAFF; EXPERTS AND CONSULTANTS.—Subject to such review as the Secretary deems necessary to assure the efficient administration of the Commission, the Commission may—

''(A) appoint an Executive Director (subject to the approval of the Secretary) and such other personnel as Federal employees under section 2105 of title 5, United States Code, as may be necessary to carry out its duties (without regard to the provisions of title 5, United States Code, governing appointments in the competitive service);

''(B) seek such assistance and support as may be required in the performance of its du-

ties from appropriate Federal departments and agencies;

''(C) enter into contracts or make other arrangements, as may be necessary for the conduct of the work of the Commission (without regard to section 3709 of the Revised Statutes (41 U.S.C. 5));

''(D) make advance, progress, and other payments which relate to the work of the Commission;

''(E) provide transportation and subsistence for persons serving without compensation; and

''(F) prescribe such rules and regulations as it deems necessary with respect to the internal organization and operation of the Commission.

''(c) RESEARCH REQUIREMENTS.—Any research conducted, supported, or synthesized under this section shall meet the following requirements:

''(1) ENSURING TRANSPARENCY, CREDIBILITY, AND ACCESS.—

''(A) The establishment of the agenda and conduct of the research shall be insulated from inappropriate political or stakeholder influence.

''(B) Methods of conducting such research shall be scientifically based.

''(C) All aspects of the prioritization of research, conduct of the research, and development of conclusions based on the research shall be transparent to all stakeholders.

''(D) The process and methods for conducting such research shall be publicly documented and available to all stakeholders.

''(E) Throughout the process of such research, the Center shall provide opportunities for all stakeholders involved to review and provide public comment on the methods and findings of such research.

''(2) USE OF CLINICAL PERSPECTIVE ADVISORY PANELS.—The research shall meet a national research priority determined under subsection (b)(2)(A) and shall consider advice given to the Center by the clinical perspective advisory panel for the national research priority.

''(3) STAKEHOLDER INPUT.—

''(A) IN GENERAL.—The Commission shall consult with patients, health care providers, health care consumer representatives, and other appropriate stakeholders with an interest in the

research through a transparent process recommended by the Commission.

"(B) SPECIFIC AREAS OF CONSULTATION.—Consultation shall include where deemed appropriate by the Commission—

"(i) recommending research priorities and questions;

"(ii) recommending research methodologies; and

"(iii) advising on and assisting with efforts to disseminate research findings.

"(C) OMBUDSMAN.—The Secretary shall designate a patient ombudsman. The ombudsman shall—

"(i) serve as an available point of contact for any patients with an interest in proposed comparative effectiveness studies by the Center; and

"(ii) ensure that any comments from patients regarding proposed comparative effectiveness studies are reviewed by the Commission.

"(4) TAKING INTO ACCOUNT POTENTIAL DIFFERENCES.—Research shall—

''(A) be designed, as appropriate, to take into account the potential for differences in the effectiveness of health care items and services used with various subpopulations such as racial and ethnic minorities, women, different age groups (including children, adolescents, adults, and seniors), and individuals with different comorbidities; and—

''(B) seek, as feasible and appropriate, to include members of such subpopulations as subjects in the research.

''(d) PUBLIC ACCESS TO COMPARATIVE EFFECTIVENESS INFORMATION.—

''(1) IN GENERAL.—Not later than 90 days after receipt by the Center or Commission, as applicable, of a relevant report described in paragraph (2) made by the Center, Commission, or clinical perspective advisory panel under this section, appropriate information contained in such report shall be posted on the official public Internet site of the Center and of the Commission, as applicable.

''(2) RELEVANT REPORTS DESCRIBED.—For purposes of this section, a relevant report is each of the following submitted by the Center or a grantee or contractor of the Center:

''(A) Any interim or progress reports as deemed appropriate by the Secretary.

''(B) Stakeholder comments.

''(C) A final report.

''(e) DISSEMINATION AND INCORPORATION OF COMPARATIVE EFFECTIVENESS INFORMATION.—

''(1) DISSEMINATION.—The Center shall provide for the dissemination of appropriate findings produced by research supported, conducted, or synthesized under this section to health care providers, patients, vendors of health information technology focused on clinical decision support, appropriate professional associations, and Federal and private health plans, and other relevant stakeholders. In disseminating such findings the Center shall—

''(A) convey findings of research so that they are comprehensible and useful to patients and providers in making health care decisions;

''(B) discuss findings and other considerations specific to certain sub-populations, risk factors, and comorbidities as appropriate;

''(C) include considerations such as limitations of research and what further research may be needed, as appropriate;

''(D) not include any data that the dissemination of which would violate the privacy of research participants or violate any confidentiality agreements made with respect to the use of data under this section; and

''(E) assist the users of health information technology focused on clinical decision support to promote the timely incorporation of such findings into clinical practices and promote the ease of use of such incorporation.

''(2) DISSEMINATION PROTOCOLS AND STRATEGIES.—The Center shall develop protocols and strategies for the appropriate dissemination of research findings in order to ensure effective communication of findings and the use and incorporation of such findings into relevant activities for the purpose of informing higher quality and more effective and efficient decisions regarding medical items and services. In developing and adopting such protocols and strategies, the Center shall consult with stakeholders concerning the types of dissemination that will be most useful to the end users of information and may provide for the utilization of multiple formats for conveying findings to different audiences, including dis-

semination to individuals with limited English proficiency.

''(f) REPORTS TO CONGRESS.—

''(1) ANNUAL REPORTS.—Beginning not later than one year after the date of the enactment of this section, the Director of the Agency of Healthcare Research and Quality and the Commission shall submit to Congress an annual report on the activities of the Center and the Commission, as well as the research, conducted under this section. Each such report shall include a discussion of the Center's compliance with subsection (c)(B)(4), including any reasons for lack of complicance with such subsection.

''(2) RECOMMENDATION FOR FAIR SHARE PER CAPITA AMOUNT FOR ALL-PAYER FINANCING.—Beginning not later than December 31, 2011, the Secretary shall submit to Congress an annual recommendation for a fair share per capita amount described in subsection (c)(1) of section 9511 of the Internal Revenue Code of 1986 for purposes of funding the CERTF under such section.

''(3) ANALYSIS AND REVIEW.—Not later than December 31, 2013, the Secretary, in consultation with the Commission, shall submit to Congress a report on all activities conducted or supported under

this section as of such date. Such report shall include an evaluation of the overall costs of such activities and an analysis of the backlog of any research proposals approved by the Commission but not funded.

''(g) FUNDING OF COMPARATIVE EFFECTIVENESS RESEARCH.—For fiscal year 2010 and each subsequent fiscal year, amounts in the Comparative Effectiveness Research Trust Fund (referred to in this section as the 'CERTF') under section 9511 of the Internal Revenue Code of 1986 shall be available, without the need for further appropriations and without fiscal year limitation, to the Secretary to carry out this section.

''(h) CONSTRUCTION.—Nothing in this section shall be construed to permit the Commission or the Center to mandate coverage, reimbursement, or other policies for any public or private payer.''.

(b) COMPARATIVE EFFECTIVENESS RESEARCH TRUST FUND; FINANCING FOR THE TRUST FUND.—For provision establishing a Comparative Effectiveness Research Trust Fund and financing such Trust Fund, see section 1802.

Subtitle B—Nursing Home Transparency

PART 1—IMPROVING TRANSPARENCY OF INFORMATION ON SKILLED NURSING FACILITIES AND NURSING FACILITIES

SEC. 1411. REQUIRED DISCLOSURE OF OWNERSHIP AND ADDITIONAL DISCLOSABLE PARTIES INFORMATION.

(a) IN GENERAL.—Section 1124 of the Social Security Act (42 U.S.C. 1320a–3) is amended by adding at the end the following new subsection:

''(c) REQUIRED DISCLOSURE OF OWNERSHIP AND ADDITIONAL DISCLOSABLE PARTIES INFORMATION.—

''(1) DISCLOSURE.—A facility (as defined in paragraph (7)(B)) shall have the information described in paragraph (3) available—

''(A) during the period beginning on the date of the enactment of this subsection and ending on the date such information is made available to the public under section 1411(b) of the America's Affordable Health Choices Act of 2009, for submission to the Secretary, the Inspector General of the Department of Health and Human Services, the State in which the facility is located, and the State long-term care

ombudsman in the case where the Secretary, the Inspector General, the State, or the State long-term care ombudsman requests such information; and

''(B) beginning on the effective date of the final regulations promulgated under paragraph (4)(A), for reporting such information in accordance with such final regulations.

Nothing in subparagraph (A) shall be construed as authorizing a facility to dispose of or delete information described in such subparagraph after the effective date of the final regulations promulgated under paragraph (4)(A).

''(2) PUBLIC AVAILABILITY OF INFORMATION.—During the period described in paragraph (1)(A), a facility shall—

''(A) make the information described in paragraph (3) available to the public upon request and update such information as may be necessary to reflect changes in such information; and

''(B) post a notice of the availability of such information in the lobby of the facility in a prominent manner.

''(3) INFORMATION DESCRIBED.—

''(A) IN GENERAL.—The following information is described in this paragraph:

''(i) The information described in subsections (a) and (b), subject to subparagraph (C).

''(ii) The identity of and information on—

''(I) each member of the governing body of the facility, including the name, title, and period of service of each such member;

''(II) each person or entity who is an officer, director, member, partner, trustee, or managing employee of the facility, including the name, title, and date of start of service of each such person or entity; and

''(III) each person or entity who is an additional disclosable party of the facility.

''(iii) The organizational structure of each person and entity described in subclauses (II) and (III) of clause (ii) and a description of the relationship of each such

person or entity to the facility and to one another.

''(B) SPECIAL RULE WHERE INFORMATION IS ALREADY REPORTED OR SUBMITTED.—To the extent that information reported by a facility to the Internal Revenue Service on Form 990, information submitted by a facility to the Securities and Exchange Commission, or information otherwise submitted to the Secretary or any other Federal agency contains the information described in clauses (i), (ii), or (iii) of subparagraph (A), the Secretary may allow, to the extent practicable, such Form or such information to meet the requirements of paragraph (1) and to be submitted in a manner specified by the Secretary.

''(C) SPECIAL RULE.—In applying subparagraph (A)(i)—

''(i) with respect to subsections (a) and (b), 'ownership or control interest' shall include direct or indirect interests, including such interests in intermediate entities; and

''(ii) subsection (a)(3)(A)(ii) shall include the owner of a whole or part interest

in any mortgage, deed of trust, note, or other obligation secured, in whole or in part, by the entity or any of the property or assets thereof, if the interest is equal to or exceeds 5 percent of the total property or assets of the entirety.

''(4) REPORTING.—

''(A) IN GENERAL.—Not later than the date that is 2 years after the date of the enactment of this subsection, the Secretary shall promulgate regulations requiring, effective on the date that is 90 days after the date on which such final regulations are published in the Federal Register, a facility to report the information described in paragraph (3) to the Secretary in a standardized format, and such other regulations as are necessary to carry out this subsection. Such final regulations shall ensure that the facility certifies, as a condition of participation and payment under the program under title XVIII or XIX, that the information reported by the facility in accordance with such final regulations is accurate and current.

''(B) GUIDANCE.—The Secretary shall provide guidance and technical assistance to States

on how to adopt the standardized format under subparagraph (A).

''(5) NO EFFECT ON EXISTING REPORTING REQUIREMENTS.—Nothing in this subsection shall reduce, diminish, or alter any reporting requirement for a facility that is in effect as of the date of the enactment of this subsection.

''(6) DEFINITIONS.—In this subsection:

''(A) ADDITIONAL DISCLOSABLE PARTY.—The term 'additional disclosable party' means, with respect to a facility, any person or entity who—

''(i) exercises operational, financial, or managerial control over the facility or a part thereof, or provides policies or procedures for any of the operations of the facility, or provides financial or cash management services to the facility;

''(ii) leases or subleases real property to the facility, or owns a whole or part interest equal to or exceeding 5 percent of the total value of such real property;

''(iii) lends funds or provides a financial guarantee to the facility in an amount which is equal to or exceeds $50,000; or

''(iv) provides management or administrative services, clinical consulting services, or accounting or financial services to the facility.

''(B) FACILITY.—The term 'facility' means a disclosing entity which is—

''(i) a skilled nursing facility (as defined in section 1819(a)); or

''(ii) a nursing facility (as defined in section 1919(a)).

''(C) MANAGING EMPLOYEE.—The term 'managing employee' means, with respect to a facility, an individual (including a general manager, business manager, administrator, director, or consultant) who directly or indirectly manages, advises, or supervises any element of the practices, finances, or operations of the facility.

''(D) ORGANIZATIONAL STRUCTURE.—The term 'organizational structure' means, in the case of—

''(i) a corporation, the officers, directors, and shareholders of the corporation who have an ownership interest in the corporation which is equal to or exceeds 5 percent;

''(ii) a limited liability company, the members and managers of the limited liability company (including, as applicable, what percentage each member and manager has of the ownership interest in the limited liability company);

''(iii) a general partnership, the partners of the general partnership;

''(iv) a limited partnership, the general partners and any limited partners of the limited partnership who have an ownership interest in the limited partnership which is equal to or exceeds 10 percent;

''(v) a trust, the trustees of the trust;

''(vi) an individual, contact information for the individual; and

''(vii) any other person or entity, such information as the Secretary determines appropriate.''.

(b) PUBLIC AVAILABILITY OF INFORMATION.—

(1) IN GENERAL.—Not later than the date that is 1 year after the date on which the final regulations promulgated under section 1124(c)(4)(A) of the Social Security Act, as added by subsection (a), are published in the Federal Register, the informa-

tion reported in accordance with such final regulations shall be made available to the public in accordance with procedures established by the Secretary.

(2) DEFINITIONS.—In this subsection:

(A) NURSING FACILITY.—The term ''nursing facility'' has the meaning given such term in section 1919(a) of the Social Security Act (42 U.S.C. 1396r(a)).

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

(C) SKILLED NURSING FACILITY.—The term ''skilled nursing facility'' has the meaning given such term in section 1819(a) of the Social Security Act (42 U.S.C. 1395i–3(a)).

(c) CONFORMING AMENDMENTS.—

(1) SKILLED NURSING FACILITIES.—Section 1819(d)(1) of the Social Security Act (42 U.S.C. 1395i–3(d)(1)) is amended by striking subparagraph (B) and redesignating subparagraph (C) as subparagraph (B).

(2) NURSING FACILITIES.—Section 1919(d)(1) of the Social Security Act (42 U.S.C. 1396r(d)(1)) is amended by striking subparagraph (B) and redesignating subparagraph (C) as subparagraph (B).

SEC. 1412. ACCOUNTABILITY REQUIREMENTS.

(a) EFFECTIVE COMPLIANCE AND ETHICS PROGRAMS.—

(1) SKILLED NURSING FACILITIES.—Section 1819(d)(1) of the Social Security Act (42 U.S.C. 1395i–3(d)(1)), as amended by section 1411(c)(1), is amended by adding at the end the following new subparagraph:

"(C) COMPLIANCE AND ETHICS PROGRAMS.—

"(i) REQUIREMENT.—On or after the date that is 36 months after the date of the enactment of this subparagraph, a skilled nursing facility shall, with respect to the entity that operates the facility (in this subparagraph referred to as the 'operating organization' or 'organization'), have in operation a compliance and ethics program that is effective in preventing and detecting criminal, civil, and administrative violations under this Act and in promoting quality of care consistent with regulations developed under clause (ii).

"(ii) DEVELOPMENT OF REGULATIONS.—

''(I) IN GENERAL.—Not later than the date that is 2 years after such date of the enactment, the Secretary, in consultation with the Inspector General of the Department of Health and Human Services, shall promulgate regulations for an effective compliance and ethics program for operating organizations, which may include a model compliance program.

''(II) DESIGN OF REGULATIONS.—Such regulations with respect to specific elements or formality of a program may vary with the size of the organization, such that larger organizations should have a more formal and rigorous program and include established written policies defining the standards and procedures to be followed by its employees. Such requirements shall specifically apply to the corporate level management of multi-unit nursing home chains.

"(III) EVALUATION.—Not later than 3 years after the date of promulgation of regulations under this clause, the Secretary shall complete an evaluation of the compliance and ethics programs required to be established under this subparagraph. Such evaluation shall determine if such programs led to changes in deficiency citations, changes in quality performance, or changes in other metrics of resident quality of care. The Secretary shall submit to Congress a report on such evaluation and shall include in such report such recommendations regarding changes in the requirements for such programs as the Secretary determines appropriate.

"(iii) REQUIREMENTS FOR COMPLIANCE AND ETHICS PROGRAMS.—In this subparagraph, the term 'compliance and ethics program' means, with respect to a skilled nursing facility, a program of the operating organization that—

''(I) has been reasonably designed, implemented, and enforced so that it generally will be effective in preventing and detecting criminal, civil, and administrative violations under this Act and in promoting quality of care; and

''(II) includes at least the required components specified in clause (iv).

''(iv) REQUIRED COMPONENTS OF PROGRAM.—The required components of a compliance and ethics program of an organization are the following:

''(I) The organization must have established compliance standards and procedures to be followed by its employees, contractors, and other agents that are reasonably capable of reducing the prospect of criminal, civil, and administrative violations under this Act.

''(II) Specific individuals within high-level personnel of the organization must have been assigned overall

responsibility to oversee compliance with such standards and procedures and have sufficient resources and authority to assure such compliance.

''(III) The organization must have used due care not to delegate substantial discretionary authority to individuals whom the organization knew, or should have known through the exercise of due diligence, had a propensity to engage in criminal, civil, and administrative violations under this Act.

''(IV) The organization must have taken steps to communicate effectively its standards and procedures to all employees and other agents, such as by requiring participation in training programs or by disseminating publications that explain in a practical manner what is required.

''(V) The organization must have taken reasonable steps to achieve compliance with its standards, such as by utilizing monitoring and auditing sys-

tems reasonably designed to detect criminal, civil, and administrative violations under this Act by its employees and other agents and by having in place and publicizing a reporting system whereby employees and other agents could report violations by others within the organization without fear of retribution.

''(VI) The standards must have been consistently enforced through appropriate disciplinary mechanisms, including, as appropriate, discipline of individuals responsible for the failure to detect an offense.

''(VII) After an offense has been detected, the organization must have taken all reasonable steps to respond appropriately to the offense and to prevent further similar offenses, including repayment of any funds to which it was not entitled and any necessary modification to its program to prevent and detect criminal, civil, and

administrative violations under this Act.

''(VIII) The organization must periodically undertake reassessment of its compliance program to identify changes necessary to reflect changes within the organization and its facilities.

''(v) COORDINATION.—The provisions of this subparagraph shall apply with respect to a skilled nursing facility in lieu of section 1874(d).''.

(2) NURSING FACILITIES.—Section 1919(d)(1) of the Social Security Act (42 U.S.C. 1396r(d)(1)), as amended by section 1411(c)(2), is amended by adding at the end the following new subparagraph:

''(C) COMPLIANCE AND ETHICS PROGRAM.—

''(i) REQUIREMENT.—On or after the date that is 36 months after the date of the enactment of this subparagraph, a nursing facility shall, with respect to the entity that operates the facility (in this subparagraph referred to as the 'operating organization' or 'organization'), have in op-

eration a compliance and ethics program that is effective in preventing and detecting criminal, civil, and administrative violations under this Act and in promoting quality of care consistent with regulations developed under clause (ii).

''(ii) DEVELOPMENT OF REGULATIONS.—

''(I) IN GENERAL.—Not later than the date that is 2 years after such date of the enactment, the Secretary, in consultation with the Inspector General of the Department of Health and Human Services, shall develop regulations for an effective compliance and ethics program for operating organizations, which may include a model compliance program.

''(II) DESIGN OF REGULATIONS.—Such regulations with respect to specific elements or formality of a program may vary with the size of the organization, such that larger organizations should have a more formal and rigorous program and include es-

tablished written policies defining the standards and procedures to be followed by its employees. Such requirements may specifically apply to the corporate level management of multi-unit nursing home chains.

''(III) EVALUATION.—Not later than 3 years after the date of promulgation of regulations under this clause the Secretary shall complete an evaluation of the compliance and ethics programs required to be established under this subparagraph. Such evaluation shall determine if such programs led to changes in deficiency citations, changes in quality performance, or changes in other metrics of resident quality of care. The Secretary shall submit to Congress a report on such evaluation and shall include in such report such recommendations regarding changes in the requirements for such programs as the Secretary determines appropriate.

''(iii) REQUIREMENTS FOR COMPLIANCE AND ETHICS PROGRAMS.—In this subparagraph, the term 'compliance and ethics program' means, with respect to a nursing facility, a program of the operating organization that—

''(I) has been reasonably designed, implemented, and enforced so that it generally will be effective in preventing and detecting criminal, civil, and administrative violations under this Act and in promoting quality of care; and

''(II) includes at least the required components specified in clause (iv).

''(iv) REQUIRED COMPONENTS OF PROGRAM.—The required components of a compliance and ethics program of an organization are the following:

''(I) The organization must have established compliance standards and procedures to be followed by its employees and other agents that are reasonably capable of reducing the pros-

pect of criminal, civil, and administrative violations under this Act.

''(II) Specific individuals within high-level personnel of the organization must have been assigned overall responsibility to oversee compliance with such standards and procedures and has sufficient resources and authority to assure such compliance.

''(III) The organization must have used due care not to delegate substantial discretionary authority to individuals whom the organization knew, or should have known through the exercise of due diligence, had a propensity to engage in criminal, civil, and administrative violations under this Act.

''(IV) The organization must have taken steps to communicate effectively its standards and procedures to all employees and other agents, such as by requiring participation in training programs or by disseminating

publications that explain in a practical manner what is required.

''(V) The organization must have taken reasonable steps to achieve compliance with its standards, such as by utilizing monitoring and auditing systems reasonably designed to detect criminal, civil, and administrative violations under this Act by its employees and other agents and by having in place and publicizing a reporting system whereby employees and other agents could report violations by others within the organization without fear of retribution.

''(VI) The standards must have been consistently enforced through appropriate disciplinary mechanisms, including, as appropriate, discipline of individuals responsible for the failure to detect an offense.

''(VII) After an offense has been detected, the organization must have taken all reasonable steps to respond appropriately to the offense and to

prevent further similar offenses, including repayment of any funds to which it was not entitled and any necessary modification to its program to prevent and detect criminal, civil, and administrative violations under this Act.

''(VIII) The organization must periodically undertake reassessment of its compliance program to identify changes necessary to reflect changes within the organization and its facilities.

''(v) COORDINATION.—The provisions of this subparagraph shall apply with respect to a nursing facility in lieu of section 1902(a)(77).''.

(b) QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT PROGRAM.—

(1) SKILLED NURSING FACILITIES.—Section 1819(b)(1)(B) of the Social Security Act (42 U.S.C. 1396r(b)(1)(B)) is amended—

(A) by striking ''ASSURANCE'' and inserting ''ASSURANCE AND QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT PROGRAM'';

(B) by designating the matter beginning with ''A nursing facility'' as a clause (i) with the heading ''IN GENERAL.—'' and the appropriate indentation; and

(C) by adding at the end the following new clause:

''(ii) QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT PROGRAM.—

''(I) IN GENERAL.—Not later than December 31, 2011, the Secretary shall establish and implement a quality assurance and performance improvement program (in this clause referred to as the 'QAPI program') for skilled nursing facilities, including multi-unit chains of such facilities. Under the QAPI program, the Secretary shall establish standards relating to such facilities and provide technical assistance to such facilities on the development of best practices in order to meet such standards. Not later than 1 year after the date on which the regulations are promulgated under subclause (II), a skilled nursing

facility must submit to the Secretary a plan for the facility to meet such standards and implement such best practices, including how to coordinate the implementation of such plan with quality assessment and assurance activities conducted under clause (i).

''(II) REGULATIONS.—The Secretary shall promulgate regulations to carry out this clause.''.

(2) NURSING FACILITIES.—Section 1919(b)(1)(B) of the Social Security Act (42 U.S.C. 1396r(b)(1)(B)) is amended—

(A) by striking ''ASSURANCE'' and inserting ''ASSURANCE AND QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT PROGRAM'';

(B) by designating the matter beginning with ''A nursing facility'' as a clause (i) with the heading ''IN GENERAL.—'' and the appropriate indentation; and

(C) by adding at the end the following new clause:

''(ii) QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT PROGRAM.—

"(I) IN GENERAL.—Not later than December 31, 2011, the Secretary shall establish and implement a quality assurance and performance improvement program (in this clause referred to as the 'QAPI program') for nursing facilities, including multi-unit chains of such facilities. Under the QAPI program, the Secretary shall establish standards relating to such facilities and provide technical assistance to such facilities on the development of best practices in order to meet such standards. Not later than 1 year after the date on which the regulations are promulgated under subclause (II), a nursing facility must submit to the Secretary a plan for the facility to meet such standards and implement such best practices, including how to coordinate the implementation of such plan with quality assessment and assurance activities conducted under clause (i).

''(II) REGULATIONS.—The Secretary shall promulgate regulations to carry out this clause.''.

(3) PROPOSAL TO REVISE QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT PROGRAMS.—The Secretary shall include in the proposed rule published under section 1888(e) of the Social Security Act (42 U.S.C. 1395yy(e)(5)(A)) for the subsequent fiscal year to the extent otherwise authorized under section 1819(b)(1)(B) or 1819(d)(1)(C) of the Social Security Act or other statutory or regulatory authority, one or more proposals for skilled nursing facilities to modify and strengthen quality assurance and performance improvement programs in such facilities. At the time of publication of such proposed rule and to the extent otherwise authorized under section 1919(b)(1)(B) or 1919(d)(1)(C) of such Act or other regulatory authority.

(4) FACILITY PLAN.—Not later than 1 year after the date on which the regulations are promulgated under subclause (II) of clause (ii) of sections 1819(b)(1)(B) and 1919(b)(1)(B) of the Social Security Act, as added by paragraphs (1) and (2), a skilled nursing facility and a nursing facility must submit to the Secretary a plan for the facility to

meet the standards under such regulations and implement such best practices, including how to coordinate the implementation of such plan with quality assessment and assurance activities conducted under clause (i) of such sections.

(c) GAO STUDY ON NURSING FACILITY UNDERCAPITALIZATION.—

(1) IN GENERAL.—The Comptroller General of the United States shall conduct a study that examines the following:

(A) The extent to which corporations that own or operate large numbers of nursing facilities, taking into account ownership type (including private equity and control interests), are undercapitalizing such facilities.

(B) The effects of such undercapitalization on quality of care, including staffing and food costs, at such facilities.

(C) Options to address such undercapitalization, such as requirements relating to surety bonds, liability insurance, or minimum capitalization.

(2) REPORT.—Not later than 18 months after the date of the enactment of this Act, the Comp-

troller General shall submit to Congress a report on the study conducted under paragraph (1).

(3) NURSING FACILITY.—In this subsection, the term ''nursing facility'' includes a skilled nursing facility.

SEC. 1413. NURSING HOME COMPARE MEDICARE WEBSITE.

(a) SKILLED NURSING FACILITIES.—

(1) IN GENERAL.—Section 1819 of the Social Security Act (42 U.S.C. 1395i–3) is amended—

(A) by redesignating subsection (i) as subsection (j); and

(B) by inserting after subsection (h) the following new subsection:

''(i) NURSING HOME COMPARE WEBSITE.—

''(1) INCLUSION OF ADDITIONAL INFORMATION.—

''(A) IN GENERAL.—The Secretary shall ensure that the Department of Health and Human Services includes, as part of the information provided for comparison of nursing homes on the official Internet website of the Federal Government for Medicare beneficiaries (commonly referred to as the 'Nursing Home Compare' Medicare website) (or a successor website), the following information in a manner

that is prominent, easily accessible, readily understandable to consumers of long-term care services, and searchable:

''(i) Information that is reported to the Secretary under section 1124(c)(4).

''(ii) Information on the 'Special Focus Facility program' (or a successor program) established by the Centers for Medicare and Medicaid Services, according to procedures established by the Secretary. Such procedures shall provide for the inclusion of information with respect to, and the names and locations of, those facilities that, since the previous quarter—

''(I) were newly enrolled in the program;

''(II) are enrolled in the program and have failed to significantly improve;

''(III) are enrolled in the program and have significantly improved;

''(IV) have graduated from the program; and

''(V) have closed voluntarily or no longer participate under this title.

''(iii) Staffing data for each facility (including resident census data and data on the hours of care provided per resident per day) based on data submitted under subsection (b)(8)(C), including information on staffing turnover and tenure, in a format that is clearly understandable to consumers of long-term care services and allows such consumers to compare differences in staffing between facilities and State and national averages for the facilities. Such format shall include—

''(I) concise explanations of how to interpret the data (such as a plain English explanation of data reflecting 'nursing home staff hours per resident day');

''(II) differences in types of staff (such as training associated with different categories of staff);

''(III) the relationship between nurse staffing levels and quality of care; and

''(IV) an explanation that appropriate staffing levels vary based on patient case mix.

''(iv) Links to State Internet websites with information regarding State survey and certification programs, links to Form 2567 State inspection reports (or a successor form) on such websites, information to guide consumers in how to interpret and understand such reports, and the facility plan of correction or other response to such report.

''(v) The standardized complaint form developed under subsection (f)(8), including explanatory material on what complaint forms are, how they are used, and how to file a complaint with the State survey and certification program and the State long-term care ombudsman program.

''(vi) Summary information on the number, type, severity, and outcome of substantiated complaints.

''(vii) The number of adjudicated instances of criminal violations by employees of a a nursing facility—

''(I) that were committed inside the facility;

''(II) with respect to such instances of violations or crimes committed inside of the facility that were the violations or crimes of abuse, neglect, and exploitation, criminal sexual abuse, or other violations or crimes that resulted in serious bodily injury; and

''(III) the number of civil monetary penalties levied against the facility, employees, contractors, and other agents.

''(B) DEADLINE FOR PROVISION OF INFORMATION.—

''(i) IN GENERAL.—Except as provided in clause (ii), the Secretary shall ensure that the information described in subparagraph (A) is included on such website (or a successor website) not later than 1 year after the date of the enactment of this subsection.

''(ii) EXCEPTION.—The Secretary shall ensure that the information described

in subparagraph (A)(i) and (A)(iii) is included on such website (or a successor website) not later than the date on which the requirements under section 1124(c)(4) and subsection (b)(8)(C)(ii) are implemented.

''(2) REVIEW AND MODIFICATION OF WEBSITE.—

''(A) IN GENERAL.—The Secretary shall establish a process—

''(i) to review the accuracy, clarity of presentation, timeliness, and comprehensiveness of information reported on such website as of the day before the date of the enactment of this subsection; and

''(ii) not later than 1 year after the date of the enactment of this subsection, to modify or revamp such website in accordance with the review conducted under clause (i).

''(B) CONSULTATION.—In conducting the review under subparagraph (A)(i), the Secretary shall consult with—

''(i) State long-term care ombudsman programs;

''(ii) consumer advocacy groups;

''(iii) provider stakeholder groups; and

''(iv) any other representatives of programs or groups the Secretary determines appropriate.''.

(2) TIMELINESS OF SUBMISSION OF SURVEY AND CERTIFICATION INFORMATION.—

(A) IN GENERAL.—Section 1819(g)(5) of the Social Security Act (42 U.S.C. 1395i–3(g)(5)) is amended by adding at the end the following new subparagraph:

''(E) SUBMISSION OF SURVEY AND CERTIFICATION INFORMATION TO THE SECRETARY.—In order to improve the timeliness of information made available to the public under subparagraph (A) and provided on the Nursing Home Compare Medicare website under subsection (i), each State shall submit information respecting any survey or certification made respecting a skilled nursing facility (including any enforcement actions taken by the State) to the Secretary not later than the date on which the State sends such information to the facility. The Secretary shall use the information submitted under the preceding sentence to update

the information provided on the Nursing Home Compare Medicare website as expeditiously as practicable but not less frequently than quarterly.''.

(B) EFFECTIVE DATE.—The amendment made by this paragraph shall take effect 1 year after the date of the enactment of this Act.

(3) SPECIAL FOCUS FACILITY PROGRAM.—Section 1819(f) of such Act is amended by adding at the end the following new paragraph:

''(8) SPECIAL FOCUS FACILITY PROGRAM.—

''(A) IN GENERAL.—The Secretary shall conduct a special focus facility program for enforcement of requirements for skilled nursing facilities that the Secretary has identified as having substantially failed to meet applicable requirement of this Act.

''(B) PERIODIC SURVEYS.—Under such program the Secretary shall conduct surveys of each facility in the program not less than once every 6 months.''.

(b) NURSING FACILITIES.—

(1) IN GENERAL.—Section 1919 of the Social Security Act (42 U.S.C. 1396r) is amended—

(A) by redesignating subsection (i) as subsection (j); and

(B) by inserting after subsection (h) the following new subsection:

''(i) NURSING HOME COMPARE WEBSITE.—

''(1) INCLUSION OF ADDITIONAL INFORMATION.—

''(A) IN GENERAL.—The Secretary shall ensure that the Department of Health and Human Services includes, as part of the information provided for comparison of nursing homes on the official Internet website of the Federal Government for Medicare beneficiaries (commonly referred to as the 'Nursing Home Compare' Medicare website) (or a successor website), the following information in a manner that is prominent, easily accessible, readily understandable to consumers of long-term care services, and searchable:

''(i) Staffing data for each facility (including resident census data and data on the hours of care provided per resident per day) based on data submitted under subsection (b)(8)(C)(ii), including information on staffing turnover and tenure, in a for-

mat that is clearly understandable to consumers of long-term care services and allows such consumers to compare differences in staffing between facilities and State and national averages for the facilities. Such format shall include—

''(I) concise explanations of how to interpret the data (such as plain English explanation of data reflecting 'nursing home staff hours per resident day');

''(II) differences in types of staff (such as training associated with different categories of staff);

''(III) the relationship between nurse staffing levels and quality of care; and

''(IV) an explanation that appropriate staffing levels vary based on patient case mix.

''(ii) Links to State Internet websites with information regarding State survey and certification programs, links to Form 2567 State inspection reports (or a successor form) on such websites, information

to guide consumers in how to interpret and understand such reports, and the facility plan of correction or other response to such report.

''(iii) The standardized complaint form developed under subsection (f)(10), including explanatory material on what complaint forms are, how they are used, and how to file a complaint with the State survey and certification program and the State long-term care ombudsman program.

''(iv) Summary information on the number, type, severity, and outcome of substantiated complaints.

''(v) The number of adjudicated instances of criminal violations by employees of a nursing facility—

''(I) that were committed inside of the facility; and

''(II) with respect to such instances of violations or crimes committed outside of the facility, that were the violations or crimes that resulted in the serious bodily injury of an elder.

''(B) DEADLINE FOR PROVISION OF INFORMATION.—

''(i) IN GENERAL.—Except as provided in clause (ii), the Secretary shall ensure that the information described in subparagraph (A) is included on such website (or a successor website) not later than 1 year after the date of the enactment of this subsection.

''(ii) EXCEPTION.—The Secretary shall ensure that the information described in subparagraph (A)(i) and (A)(iii) is included on such website (or a successor website) not later than the date on which the requirements under section 1124(c)(4) and subsection (b)(8)(C)(ii) are implemented.

''(2) REVIEW AND MODIFICATION OF WEBSITE.—

''(A) IN GENERAL.—The Secretary shall establish a process—

''(i) to review the accuracy, clarity of presentation, timeliness, and comprehensiveness of information reported on such

website as of the day before the date of the enactment of this subsection; and

''(ii) not later than 1 year after the date of the enactment of this subsection, to modify or revamp such website in accordance with the review conducted under clause (i).

''(B) CONSULTATION.—In conducting the review under subparagraph (A)(i), the Secretary shall consult with—

''(i) State long-term care ombudsman programs;

''(ii) consumer advocacy groups;

''(iii) provider stakeholder groups;

''(iv) skilled nursing facility employees and their representatives; and

''(v) any other representatives of programs or groups the Secretary determines appropriate.''.

(2) TIMELINESS OF SUBMISSION OF SURVEY AND CERTIFICATION INFORMATION.—

(A) IN GENERAL.—Section 1919(g)(5) of the Social Security Act (42 U.S.C. 1396r(g)(5)) is amended by adding at the end the following new subparagraph:

''(E) SUBMISSION OF SURVEY AND CERTIFICATION INFORMATION TO THE SECRETARY.—In order to improve the timeliness of information made available to the public under subparagraph (A) and provided on the Nursing Home Compare Medicare website under subsection (i), each State shall submit information respecting any survey or certification made respecting a nursing facility (including any enforcement actions taken by the State) to the Secretary not later than the date on which the State sends such information to the facility. The Secretary shall use the information submitted under the preceding sentence to update the information provided on the Nursing Home Compare Medicare website as expeditiously as practicable but not less frequently than quarterly.''.

(B) EFFECTIVE DATE.—The amendment made by this paragraph shall take effect 1 year after the date of the enactment of this Act.

(3) SPECIAL FOCUS FACILITY PROGRAM.—Section 1919(f) of such Act is amended by adding at the end of the following new paragraph:

''(10) SPECIAL FOCUS FACILITY PROGRAM.—

''(A) IN GENERAL.—The Secretary shall conduct a special focus facility program for enforcement of requirements for nursing facilities that the Secretary has identified as having substantially failed to meet applicable requirements of this Act.

''(B) PERIODIC SURVEYS.—Under such program the Secretary shall conduct surveys of each facility in the program not less often than once every 6 months.''.

(c) AVAILABILITY OF REPORTS ON SURVEYS, CERTIFICATIONS, AND COMPLAINT INVESTIGATIONS.—

(1) SKILLED NURSING FACILITIES.—Section 1819(d)(1) of the Social Security Act (42 U.S.C. 1395i–3(d)(1)), as amended by sections 1411 and 1412, is amended by adding at the end the following new subparagraph:

''(D) AVAILABILITY OF SURVEY, CERTIFICATION, AND COMPLAINT INVESTIGATION REPORTS.—A skilled nursing facility must—

''(i) have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years available for any individual to review upon request; and

''(ii) post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. The facility shall not make available under clause (i) identifying information about complainants or residents.''.

(2) NURSING FACILITIES.—Section 1919(d)(1) of the Social Security Act (42 U.S.C. 1396r(d)(1)), as amended by sections 1411 and 1412, is amended by adding at the end the following new subparagraph:

''(D) AVAILABILITY OF SURVEY, CERTIFICATION, AND COMPLAINT INVESTIGATION REPORTS.—A nursing facility must—

''(i) have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years available for any individual to review upon request; and

''(ii) post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. The facility shall not make available under clause (i) identifying information about complainants or residents.''.

(3) EFFECTIVE DATE.—The amendments made by this subsection shall take effect 1 year after the date of the enactment of this Act.

(d) GUIDANCE TO STATES ON FORM 2567 STATE INSPECTION REPORTS AND COMPLAINT INVESTIGATION REPORTS.—

(1) GUIDANCE.—The Secretary of Health and Human Services (in this subtitle referred to as the ''Secretary'') shall provide guidance to States on how States can establish electronic links to Form 2567 State inspection reports (or a successor form), complaint investigation reports, and a facility's plan of correction or other response to such Form 2567 State inspection reports (or a successor form) on the Internet website of the State that provides information on skilled nursing facilities and nursing facilities and the Secretary shall, if possible, include such information on Nursing Home Compare.

(2) REQUIREMENT.—Section 1902(a)(9) of the Social Security Act (42 U.S.C. 1396a(a)(9)) is amended—

(A) by striking ''and'' at the end of subparagraph (B);

(B) by striking the semicolon at the end of subparagraph (C) and inserting '', and''; and

(C) by adding at the end the following new subparagraph:

''(D) that the State maintain a consumer-oriented website providing useful information to consumers regarding all skilled nursing facilities and all nursing facilities in the State, including for each facility, Form 2567 State inspection reports (or a successor form), complaint investigation reports, the facility's plan of correction, and such other information that the State or the Secretary considers useful in assisting the public to assess the quality of long term care options and the quality of care provided by individual facilities;''.

(3) DEFINITIONS.—In this subsection:

(A) NURSING FACILITY.—The term ''nursing facility'' has the meaning given such term in section 1919(a) of the Social Security Act (42 U.S.C. 1396r(a)).

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

(C) SKILLED NURSING FACILITY.—The term ''skilled nursing facility'' has the meaning

given such term in section 1819(a) of the Social Security Act (42 U.S.C. 1395i–3(a)).

SEC. 1414. REPORTING OF EXPENDITURES.

Section 1888 of the Social Security Act (42 U.S.C. 1395yy) is amended by adding at the end the following new subsection:

''(f) REPORTING OF DIRECT CARE EXPENDITURES.—

''(1) IN GENERAL.—For cost reports submitted under this title for cost reporting periods beginning on or after the date that is 3 years after the date of the enactment of this subsection, skilled nursing facilities shall separately report expenditures for wages and benefits for direct care staff (breaking out (at a minimum) registered nurses, licensed professional nurses, certified nurse assistants, and other medical and therapy staff).

''(2) MODIFICATION OF FORM.—The Secretary, in consultation with private sector accountants experienced with skilled nursing facility cost reports, shall redesign such reports to meet the requirement of paragraph (1) not later than 1 year after the date of the enactment of this subsection.

''(3) CATEGORIZATION BY FUNCTIONAL ACCOUNTS.—Not later than 30 months after the date

of the enactment of this subsection, the Secretary, working in consultation with the Medicare Payment Advisory Commission, the Inspector General of the Department of Health and Human Services, and other expert parties the Secretary determines appropriate, shall take the expenditures listed on cost reports, as modified under paragraph (1), submitted by skilled nursing facilities and categorize such expenditures, regardless of any source of payment for such expenditures, for each skilled nursing facility into the following functional accounts on an annual basis:

''(A) Spending on direct care services (including nursing, therapy, and medical services).

''(B) Spending on indirect care (including housekeeping and dietary services).

''(C) Capital assets (including building and land costs).

''(D) Administrative services costs.

''(4) AVAILABILITY OF INFORMATION SUBMITTED.—The Secretary shall establish procedures to make information on expenditures submitted under this subsection readily available to interested parties upon request, subject to such requirements

as the Secretary may specify under the procedures established under this paragraph.''.

SEC. 1415. STANDARDIZED COMPLAINT FORM.

(a) SKILLED NURSING FACILITIES.—

(1) DEVELOPMENT BY THE SECRETARY.—Section 1819(f) of the Social Security Act (42 U.S.C. 1395i–3(f)), as amended by section 1413(a)(3), is amended by adding at the end the following new paragraph:

''(9) STANDARDIZED COMPLAINT FORM.—The Secretary shall develop a standardized complaint form for use by a resident (or a person acting on the resident's behalf) in filing a complaint with a State survey and certification agency and a State long-term care ombudsman program with respect to a skilled nursing facility.''.

(2) STATE REQUIREMENTS.—Section 1819(e) of the Social Security Act (42 U.S.C. 1395i–3(e)) is amended by adding at the end the following new paragraph:

''(6) COMPLAINT PROCESSES AND WHISTLEBLOWER PROTECTION.—

''(A) COMPLAINT FORMS.—The State must make the standardized complaint form devel-

oped under subsection (f)(9) available upon request to—

"(i) a resident of a skilled nursing facility;

"(ii) any person acting on the resident's behalf; and

"(iii) any person who works at a skilled nursing facility or is a representative of such a worker.

"(B) COMPLAINT RESOLUTION PROCESS.—The State must establish a complaint resolution process in order to ensure that a resident, the legal representative of a resident of a skilled nursing facility, or other responsible party is not retaliated against if the resident, legal representative, or responsible party has complained, in good faith, about the quality of care or other issues relating to the skilled nursing facility, that the legal representative of a resident of a skilled nursing facility or other responsible party is not denied access to such resident or otherwise retaliated against if such representative party has complained, in good faith, about the quality of care provided by the facility or other issues relating to the facility,

and that a person who works at a skilled nursing facility is not retaliated against if the worker has complained, in good faith, about quality of care or services or an issue relating to the quality of care or services provided at the facility, whether the resident, legal representative, other responsible party, or worker used the form developed under subsection (f)(9) or some other method for submitting the complaint. Such complaint resolution process shall include—

''(i) procedures to assure accurate tracking of complaints received, including notification to the complainant that a complaint has been received;

''(ii) procedures to determine the likely severity of a complaint and for the investigation of the complaint;

''(iii) deadlines for responding to a complaint and for notifying the complainant of the outcome of the investigation; and

''(iv) procedures to ensure that the identity of the complainant will be kept confidential.

''(C) WHISTLEBLOWER PROTECTION.—

''(i) PROHIBITION AGAINST RETALIATION.—No person who works at a skilled nursing facility may be penalized, discriminated, or retaliated against with respect to any aspect of employment, including discharge, promotion, compensation, terms, conditions, or privileges of employment, or have a contract for services terminated, because the person (or anyone acting at the person's request) complained, in good faith, about the quality of care or services provided by a nursing facility or about other issues relating to quality of care or services, whether using the form developed under subsection (f)(9) or some other method for submitting the complaint.

''(ii) RETALIATORY REPORTING.—A skilled nursing facility may not file a complaint or a report against a person who works (or has worked at the facility with the appropriate State professional disciplinary agency because the person (or anyone acting at the person's request) complained in good faith, as described in clause (i).

"(iii) COMMENCEMENT OF ACTION.—Any person who believes the person has been penalized, discriminated , or retaliated against or had a contract for services terminated in violation of clause (i) or against whom a complaint has been filed in violation of clause (ii) may bring an action at law or equity in the appropriate district court of the United States, which shall have jurisdiction over such action without regard to the amount in controversy or the citizenship of the parties, and which shall have jurisdiction to grant complete relief, including, but not limited to, injunctive relief (such as reinstatement, compensatory damages (which may include reimbursement of lost wages, compensation, and benefits), costs of litigation (including reasonable attorney and expert witness fees), exemplary damages where appropriate, and such other relief as the court deems just and proper.

"(iv) RIGHTS NOT WAIVABLE.—The rights protected by this paragraph may not be diminished by contract or other agree-

ment, and nothing in this paragraph shall be construed to diminish any greater or additional protection provided by Federal or State law or by contract or other agreement.

''(v) REQUIREMENT TO POST NOTICE OF EMPLOYEE RIGHTS.—Each skilled nursing facility shall post conspicuously in an appropriate location a sign (in a form specified by the Secretary) specifying the rights of persons under this paragraph and including a statement that an employee may file a complaint with the Secretary against a skilled nursing facility that violates the provisions of this paragraph and information with respect to the manner of filing such a complaint.

''(D) RULE OF CONSTRUCTION.—Nothing in this paragraph shall be construed as preventing a resident of a skilled nursing facility (or a person acting on the resident's behalf) from submitting a complaint in a manner or format other than by using the standardized complaint form developed under subsection (f)(9) (including submitting a complaint orally).

''(E) GOOD FAITH DEFINED.—For purposes of this paragraph, an individual shall be deemed to be acting in good faith with respect to the filing of a complaint if the individual reasonably believes—

''(i) the information reported or disclosed in the complaint is true; and

''(ii) the violation of this title has occurred or may occur in relation to such information.''.

(b) NURSING FACILITIES.—

(1) DEVELOPMENT BY THE SECRETARY.—Section 1919(f) of the Social Security Act (42 U.S.C. 1395i–3(f)), as amended by section 1413(b), is amended by adding at the end the following new paragraph:

''(11) STANDARDIZED COMPLAINT FORM.—The Secretary shall develop a standardized complaint form for use by a resident (or a person acting on the resident's behalf) in filing a complaint with a State survey and certification agency and a State long-term care ombudsman program with respect to a nursing facility.''.

(2) STATE REQUIREMENTS.—Section 1919(e) of the Social Security Act (42 U.S.C. 1395i–3(e)) is

amended by adding at the end the following new paragraph:

''(8) COMPLAINT PROCESSES AND WHISTLEBLOWER PROTECTION.—

''(A) COMPLAINT FORMS.—The State must make the standardized complaint form developed under subsection (f)(11) available upon request to—

''(i) a resident of a nursing facility;

''(ii) any person acting on the resident's behalf; and

''(iii) any person who works at a nursing facility or a representative of such a worker.

''(B) COMPLAINT RESOLUTION PROCESS.—The State must establish a complaint resolution process in order to ensure that a resident, the legal representative of a resident of a nursing facility, or other responsible party is not retaliated against if the resident, legal representative, or responsible party has complained, in good faith, about the quality of care or other issues relating to the nursing facility, that the legal representative of a resident of a nursing facility or other responsible party is not denied

access to such resident or otherwise retaliated against if such representative party has complained, in good faith, about the quality of care provided by the facility or other issues relating to the facility, and that a person who works at a nursing facility is not retaliated against if the worker has complained, in good faith, about quality of care or services or an issue relating to the quality of care or services provided at the facility, whether the resident, legal representative, other responsible party, or worker used the form developed under subsection (f)(11) or some other method for submitting the complaint. Such complaint resolution process shall include—

''(i) procedures to assure accurate tracking of complaints received, including notification to the complainant that a complaint has been received;

''(ii) procedures to determine the likely severity of a complaint and for the investigation of the complaint;

''(iii) deadlines for responding to a complaint and for notifying the complain-

ant of the outcome of the investigation; and

''(iv) procedures to ensure that the identity of the complainant will be kept confidential.

''(C) WHISTLEBLOWER PROTECTION.—

''(i) PROHIBITION AGAINST RETALIATION.—No person who works at a nursing facility may be penalized, discriminated, or retaliated against with respect to any aspect of employment, including discharge, promotion, compensation, terms, conditions, or privileges of employment, or have a contract for services terminated, because the person (or anyone acting at the person's request) complained, in good faith, about the quality of care or services provided by a nursing facility or about other issues relating to quality of care or services, whether using the form developed under subsection (f)(11) or some other method for submitting the complaint.

''(ii) RETALIATORY REPORTING.—A nursing facility may not file a complaint or a report against a person who works (or

has worked at the facility with the appropriate State professional disciplinary agency because the person (or anyone acting at the person's request) complained in good faith, as described in clause (i).

''(iii) COMMENCEMENT OF ACTION.—Any person who believes the person has been penalized, discriminated, or retaliated against or had a contract for services terminated in violation of clause (i) or against whom a complaint has been filed in violation of clause (ii) may bring an action at law or equity in the appropriate district court of the United States, which shall have jurisdiction over such action without regard to the amount in controversy or the citizenship of the parties, and which shall have jurisdiction to grant complete relief, including, but not limited to, injunctive relief (such as reinstatement, compensatory damages (which may include reimbursement of lost wages, compensation, and benefits), costs of litigation (including reasonable attorney and expert witness fees), exemplary damages where appropriate, and

such other relief as the court deems just and proper.

''(iv) RIGHTS NOT WAIVABLE.—The rights protected by this paragraph may not be diminished by contract or other agreement, and nothing in this paragraph shall be construed to diminish any greater or additional protection provided by Federal or State law or by contract or other agreement.

''(v) REQUIREMENT TO POST NOTICE OF EMPLOYEE RIGHTS.—Each nursing facility shall post conspicuously in an appropriate location a sign (in a form specified by the Secretary) specifying the rights of persons under this paragraph and including a statement that an employee may file a complaint with the Secretary against a nursing facility that violates the provisions of this paragraph and information with respect to the manner of filing such a complaint.

''(D) RULE OF CONSTRUCTION.—Nothing in this paragraph shall be construed as preventing a resident of a nursing facility (or a

person acting on the resident's behalf) from submitting a complaint in a manner or format other than by using the standardized complaint form developed under subsection (f)(11) (including submitting a complaint orally).

''(E) GOOD FAITH DEFINED.—For purposes of this paragraph, an individual shall be deemed to be acting in good faith with respect to the filing of a complaint if the individual reasonably believes—

''(i) the information reported or disclosed in the complaint is true; and

''(ii) the violation of this title has occurred or may occur in relation to such information.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall take effect 1 year after the date of the enactment of this Act.

SEC. 1416. ENSURING STAFFING ACCOUNTABILITY.

(a) SKILLED NURSING FACILITIES.—Section 1819(b)(8) of the Social Security Act (42 U.S.C. 1395i–3(b)(8)) is amended by adding at the end the following new subparagraph:

''(C) SUBMISSION OF STAFFING INFORMATION BASED ON PAYROLL DATA IN A UNIFORM

FORMAT.—Beginning not later than 2 years after the date of the enactment of this subparagraph, and after consulting with State long-term care ombudsman programs, consumer advocacy groups, provider stakeholder groups, employees and their representatives, and other parties the Secretary deems appropriate, the Secretary shall require a skilled nursing facility to electronically submit to the Secretary direct care staffing information (including information with respect to agency and contract staff) based on payroll and other verifiable and auditable data in a uniform format (according to specifications established by the Secretary in consultation with such programs, groups, and parties). Such specifications shall require that the information submitted under the preceding sentence—

"(i) specify the category of work a certified employee performs (such as whether the employee is a registered nurse, licensed practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other medical personnel);

''(ii) include resident census data and information on resident case mix;

''(iii) include a regular reporting schedule; and

''(iv) include information on employee turnover and tenure and on the hours of care provided by each category of certified employees referenced in clause (i) per resident per day.

Nothing in this subparagraph shall be construed as preventing the Secretary from requiring submission of such information with respect to specific categories, such as nursing staff, before other categories of certified employees. Information under this subparagraph with respect to agency and contract staff shall be kept separate from information on employee staffing.''.

(b) NURSING FACILITIES.—Section 1919(b)(8) of the Social Security Act (42 U.S.C. 1396r(b)(8)) is amended by adding at the end the following new subparagraph:

''(C) SUBMISSION OF STAFFING INFORMATION BASED ON PAYROLL DATA IN A UNIFORM FORMAT.—Beginning not later than 2 years after the date of the enactment of this subparagraph, and after consulting with State long-

term care ombudsman programs, consumer advocacy groups, provider stakeholder groups, employees and their representatives, and other parties the Secretary deems appropriate, the Secretary shall require a nursing facility to electronically submit to the Secretary direct care staffing information (including information with respect to agency and contract staff) based on payroll and other verifiable and auditable data in a uniform format (according to specifications established by the Secretary in consultation with such programs, groups, and parties). Such specifications shall require that the information submitted under the preceding sentence—

''(i) specify the category of work a certified employee performs (such as whether the employee is a registered nurse, licensed practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other medical personnel);

''(ii) include resident census data and information on resident case mix;

''(iii) include a regular reporting schedule; and

''(iv) include information on employee turnover and tenure and on the hours of care provided by each category of certified employees referenced in clause (i) per resident per day.

Nothing in this subparagraph shall be construed as preventing the Secretary from requiring submission of such information with respect to specific categories, such as nursing staff, before other categories of certified employees. Information under this subparagraph with respect to agency and contract staff shall be kept separate from information on employee staffing.''.

PART 2—TARGETING ENFORCEMENT

SEC. 1421. CIVIL MONEY PENALTIES.

(a) SKILLED NURSING FACILITIES.—

(1) IN GENERAL.—Section 1819(h)(2)(B)(ii) of the Social Security Act (42 U.S.C. 1395i–3(h)(2)(B)(ii)) is amended to read as follows:

''(ii) AUTHORITY WITH RESPECT TO CIVIL MONEY PENALTIES.—

''(I) AMOUNT.—The Secretary may impose a civil money penalty in the applicable per instance or per day amount (as defined in subclause (II)

and (III)) for each day or instance, respectively, of noncompliance (as determined appropriate by the Secretary).

''(II) APPLICABLE PER INSTANCE AMOUNT.—In this clause, the term 'applicable per instance amount' means—

''(aa) in the case where the deficiency is found to be a direct proximate cause of death of a resident of the facility, an amount not to exceed $100,000.

''(bb) in each case of a deficiency where the facility is cited for actual harm or immediate jeopardy, an amount not less than $3,050 and not more than $25,000; and

''(cc) in each case of any other deficiency, an amount not less than $250 and not to exceed $3050.

"(III) APPLICABLE PER DAY AMOUNT.—In this clause, the term 'applicable per day amount' means—

"(aa) in each case of a deficiency where the facility is cited for actual harm or immediate jeopardy, an amount not less than $3,050 and not more than $25,000 and

"(bb) in each case of any other deficiency, an amount not less than $250 and not to exceed $3,050.

"(IV) REDUCTION OF CIVIL MONEY PENALTIES IN CERTAIN CIRCUMSTANCES.—Subject to subclauses (V) and (VI), in the case where a facility self-reports and promptly corrects a deficiency for which a penalty was imposed under this clause not later than 10 calendar days after the date of such imposition, the Secretary may reduce the amount of the penalty imposed by not more than 50 percent.

"(V) PROHIBITION ON REDUCTION FOR CERTAIN DEFICIENCIES.—

"(aa) REPEAT DEFICIENCIES.—The Secretary may not reduce under subclause (IV) the amount of a penalty if the deficiency is a repeat deficiency.

"(bb) CERTAIN OTHER DEFICIENCIES.—The Secretary may not reduce under subclause (IV) the amount of a penalty if the penalty is imposed for a deficiency described in subclause (II)(aa) or (III)(aa) and the actual harm or widespread harm immediately jeopardizes the health or safety of a resident or residents of the facility, or if the penalty is imposed for a deficiency described in subclause (II)(bb).

"(VI) LIMITATION ON AGGREGATE REDUCTIONS.—The aggregate reduction in a penalty under subclause (IV) may not exceed 35 percent

on the basis of self-reporting, on the basis of a waiver or an appeal (as provided for under regulations under section 488.436 of title 42, Code of Federal Regulations), or on the basis of both.

''(VII) COLLECTION OF CIVIL MONEY PENALTIES.—In the case of a civil money penalty imposed under this clause, the Secretary—

''(aa) subject to item (cc), shall, not later than 30 days after the date of imposition of the penalty, provide the opportunity for the facility to participate in an independent informal dispute resolution process which generates a written record prior to the collection of such penalty, but such opportunity shall not affect the responsibility of the State survey agency for making final recommendations for such penalties;

''(bb) in the case where the penalty is imposed for each day of noncompliance, shall not impose a penalty for any day during the period beginning on the initial day of the imposition of the penalty and ending on the day on which the informal dispute resolution process under item (aa) is completed;

''(cc) may provide for the collection of such civil money penalty and the placement of such amounts collected in an escrow account under the direction of the Secretary on the earlier of the date on which the informal dispute resolution process under item (aa) is completed or the date that is 90 days after the date of the imposition of the penalty;

''(dd) may provide that such amounts collected are kept in

such account pending the resolution of any subsequent appeals;

''(ee) in the case where the facility successfully appeals the penalty, may provide for the return of such amounts collected (plus interest) to the facility; and

''(ff) in the case where all such appeals are unsuccessful, may provide that some portion of such amounts collected may be used to support activities that benefit residents, including assistance to support and protect residents of a facility that closes (voluntarily or involuntarily) or is decertified (including offsetting costs of relocating residents to home and community-based settings or another facility), projects that support resident and family councils and other consumer involvement in assuring quality care in facilities, and facility improvement initiatives approved by

the Secretary (including joint training of facility staff and surveyors, technical assistance for facilities under quality assurance programs, the appointment of temporary management, and other activities approved by the Secretary).

''(VIII) PROCEDURE.—The provisions of section 1128A (other than subsections (a) and (b) and except to the extent that such provisions require a hearing prior to the imposition of a civil money penalty) shall apply to a civil money penalty under this clause in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).''.

(2) CONFORMING AMENDMENT.—The second sentence of section 1819(h)(5) of the Social Security Act (42 U.S.C. 1395i–3(h)(5)) is amended by inserting ''(ii),''after ''(i),''.

(b) NURSING FACILITIES.—

(1) PENALTIES IMPOSED BY THE STATE.—

(A) IN GENERAL.—Section 1919(h)(2) of the Social Security Act (42 U.S.C. 1396r(h)(2)) is amended—

(i) in subparagraph (A)(ii), by striking the first sentence and inserting the following: ''A civil money penalty in accordance with subparagraph (G).''; and

(ii) by adding at the end the following new subparagraph:

''(G) CIVIL MONEY PENALTIES.—

''(i) IN GENERAL.—The State may impose a civil money penalty under subparagraph (A)(ii) in the applicable per instance or per day amount (as defined in subclause (II) and (III)) for each day or instance, respectively, of noncompliance (as determined appropriate by the Secretary).

''(ii) APPLICABLE PER INSTANCE AMOUNT.—In this subparagraph, the term 'applicable per instance amount' means—

''(I) in the case where the deficiency is found to be a direct proximate cause of death of a resident of the facility, an amount not to exceed $100,000.

''(II) in each case of a deficiency where the facility is cited for actual harm or immediate jeopardy, an amount not less than $3,050 and not more than $25,000; and

''(III) in each case of any other deficiency, an amount not less than $250 and not to exceed $3050.

''(iii) APPLICABLE PER DAY AMOUNT.—In this subparagraph, the term 'applicable per day amount' means—

''(I) in each case of a deficiency where the facility is cited for actual harm or immediate jeopardy, an amount not less than $3,050 and not more than $25,000 and

''(II) in each case of any other deficiency, an amount not less than $250 and not to exceed $3,050.

''(iv) REDUCTION OF CIVIL MONEY PENALTIES IN CERTAIN CIRCUMSTANCES.—Subject to clauses (v) and (vi), in the case where a facility self-reports and promptly corrects a deficiency for which a penalty was imposed under

subparagraph (A)(ii) not later than 10 calendar days after the date of such imposition, the State may reduce the amount of the penalty imposed by not more than 50 percent.

''(v) PROHIBITION ON REDUCTION FOR CERTAIN DEFICIENCIES.—

''(I) REPEAT DEFICIENCIES.—The State may not reduce under clause (iv) the amount of a penalty if the State had reduced a penalty imposed on the facility in the preceding year under such clause with respect to a repeat deficiency.

''(II) CERTAIN OTHER DEFICIENCIES.—The State may not reduce under clause (iv) the amount of a penalty if the penalty is imposed for a deficiency described in clause (ii)(II) or (iii)(I) and the actual harm or widespread harm that immediately jeopardizes the health or safety of a resident or residents of the facility, or if the penalty is imposed for a deficiency described in clause (ii)(I).

''(III) LIMITATION ON AGGREGATE REDUCTIONS.—The aggregate reduction in a penalty under clause (iv) may not exceed 35 percent on the basis of self-reporting, on the basis of a waiver or an appeal (as provided for under regulations under section 488.436 of title 42, Code of Federal Regulations), or on the basis of both.

''(iv) COLLECTION OF CIVIL MONEY PENALTIES.—In the case of a civil money penalty imposed under subparagraph (A)(ii), the State—

''(I) subject to subclause (III), shall, not later than 30 days after the date of imposition of the penalty, provide the opportunity for the facility to participate in an independent informal dispute resolution process which generates a written record prior to the collection of such penalty, but such opportunity shall not affect the responsibility of the State survey agency for making final recommendations for such penalties;

''(II) in the case where the penalty is imposed for each day of noncompliance, shall not impose a penalty for any day during the period beginning on the initial day of the imposition of the penalty and ending on the day on which the informal dispute resolution process under subclause (I) is completed;

''(III) may provide for the collection of such civil money penalty and the placement of such amounts collected in an escrow account under the direction of the State on the earlier of the date on which the informal dispute resolution process under subclause (I) is completed or the date that is 90 days after the date of the imposition of the penalty;

''(IV) may provide that such amounts collected are kept in such account pending the resolution of any subsequent appeals;

''(V) in the case where the facility successfully appeals the penalty,

may provide for the return of such amounts collected (plus interest) to the facility; and

''(VI) in the case where all such appeals are unsuccessful, may provide that such funds collected shall be used for the purposes described in the second sentence of subparagraph (A)(ii).''.

(B) CONFORMING AMENDMENT.—The second sentence of section 1919(h)(2)(A)(ii) of the Social Security Act (42 U.S.C. 1396r(h)(2)(A)(ii)) is amended by inserting before the period at the end the following: '', and some portion of such funds may be used to support activities that benefit residents, including assistance to support and protect residents of a facility that closes (voluntarily or involuntarily) or is decertified (including offsetting costs of relocating residents to home and community-based settings or another facility), projects that support resident and family councils and other consumer involvement in assuring quality care in facilities, and facility improvement initiatives approved by the Secretary (including joint

training of facility staff and surveyors, providing technical assistance to facilities under quality assurance programs, the appointment of temporary management, and other activities approved by the Secretary)''.

(2) PENALTIES IMPOSED BY THE SECRETARY.—

(A) IN GENERAL.—Section 1919(h)(3)(C)(ii) of the Social Security Act (42 U.S.C. 1396r(h)(3)(C)) is amended to read as follows:

''(ii) AUTHORITY WITH RESPECT TO CIVIL MONEY PENALTIES.—

''(I) AMOUNT.—Subject to subclause (II), the Secretary may impose a civil money penalty in an amount not to exceed $10,000 for each day or each instance of noncompliance (as determined appropriate by the Secretary).

''(II) REDUCTION OF CIVIL MONEY PENALTIES IN CERTAIN CIRCUMSTANCES.—Subject to subclause (III), in the case where a facility self-reports and promptly corrects a defi-

ciency for which a penalty was imposed under this clause not later than 10 calendar days after the date of such imposition, the Secretary may reduce the amount of the penalty imposed by not more than 50 percent.

''(III) PROHIBITION ON REDUCTION FOR REPEAT DEFICIENCIES.—The Secretary may not reduce the amount of a penalty under subclause (II) if the Secretary had reduced a penalty imposed on the facility in the preceding year under such subclause with respect to a repeat deficiency.

''(IV) COLLECTION OF CIVIL MONEY PENALTIES.—In the case of a civil money penalty imposed under this clause, the Secretary—

''(aa) subject to item (bb), shall, not later than 30 days after the date of imposition of the penalty, provide the opportunity for the facility to participate in an independent informal dispute resolution process which

generates a written record prior to the collection of such penalty;

''(bb) in the case where the penalty is imposed for each day of noncompliance, shall not impose a penalty for any day during the period beginning on the initial day of the imposition of the penalty and ending on the day on which the informal dispute resolution process under item (aa) is completed;

''(cc) may provide for the collection of such civil money penalty and the placement of such amounts collected in an escrow account under the direction of the Secretary on the earlier of the date on which the informal dispute resolution process under item (aa) is completed or the date that is 90 days after the date of the imposition of the penalty;

"(dd) may provide that such amounts collected are kept in such account pending the resolution of any subsequent appeals;

"(ee) in the case where the facility successfully appeals the penalty, may provide for the return of such amounts collected (plus interest) to the facility; and

"(ff) in the case where all such appeals are unsuccessful, may provide that some portion of such amounts collected may be used to support activities that benefit residents, including assistance to support and protect residents of a facility that closes (voluntarily or involuntarily) or is decertified (including offsetting costs of relocating residents to home and community-based settings or another facility), projects that support resident and family councils and other consumer involvement in assuring quality

care in facilities, and facility improvement initiatives approved by the Secretary (including joint training of facility staff and surveyors, technical assistance for facilities under quality assurance programs, the appointment of temporary management, and other activities approved by the Secretary).

''(V) PROCEDURE.—The provisions of section 1128A (other than subsections (a) and (b) and except to the extent that such provisions require a hearing prior to the imposition of a civil money penalty) shall apply to a civil money penalty under this clause in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).''.

(B) CONFORMING AMENDMENT.—Section 1919(h)(8) of the Social Security Act (42 U.S.C. 1396r(h)(5)(8)) is amended by inserting ''and in paragraph (3)(C)(ii)'' after ''paragraph (2)(A)''.

(c) EFFECTIVE DATE.—The amendments made by this section shall take effect 1 year after the date of the enactment of this Act.

SEC. 1422. NATIONAL INDEPENDENT MONITOR PILOT PROGRAM.

(a) ESTABLISHMENT.—

(1) IN GENERAL.—The Secretary, in consultation with the Inspector General of the Department of Health and Human Services, shall establish a pilot program (in this section referred to as the ''pilot program'') to develop, test, and implement use of an independent monitor to oversee interstate and large intrastate chains of skilled nursing facilities and nursing facilities.

(2) SELECTION.—The Secretary shall select chains of skilled nursing facilities and nursing facilities described in paragraph (1) to participate in the pilot program from among those chains that submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require.

(3) DURATION.—The Secretary shall conduct the pilot program for a two-year period.

(4) IMPLEMENTATION.—The Secretary shall implement the pilot program not later than one year after the date of the enactment of this Act.

(b) REQUIREMENTS.—The Secretary shall evaluate chains selected to participate in the pilot program based on criteria selected by the Secretary, including where evidence suggests that one or more facilities of the chain are experiencing serious safety and quality of care problems. Such criteria may include the evaluation of a chain that includes one or more facilities participating in the ''Special Focus Facility'' program (or a successor program) or one or more facilities with a record of repeated serious safety and quality of care deficiencies.

(c) RESPONSIBILITIES OF THE INDEPENDENT MONITOR.—An independent monitor that enters into a contract with the Secretary to participate in the conduct of such program shall—

(1) conduct periodic reviews and prepare root-cause quality and deficiency analyses of a chain to assess if facilities of the chain are in compliance with State and Federal laws and regulations applicable to the facilities;

(2) undertake sustained oversight of the chain, whether publicly or privately held, to involve the owners of the chain and the principal business part-

ners of such owners in facilitating compliance by facilities of the chain with State and Federal laws and regulations applicable to the facilities;

(3) analyze the management structure, distribution of expenditures, and nurse staffing levels of facilities of the chain in relation to resident census, staff turnover rates, and tenure;

(4) report findings and recommendations with respect to such reviews, analyses, and oversight to the chain and facilities of the chain, to the Secretary and to relevant States; and

(5) publish the results of such reviews, analyses, and oversight.

(d) IMPLEMENTATION OF RECOMMENDATIONS.—

(1) RECEIPT OF FINDING BY CHAIN.—Not later than 10 days after receipt of a finding of an independent monitor under subsection (c)(4), a chain participating in the pilot program shall submit to the independent monitor a report—

(A) outlining corrective actions the chain will take to implement the recommendations in such report; or

(B) indicating that the chain will not implement such recommendations and why it will not do so.

(2) RECEIPT OF REPORT BY INDEPENDENT MONITOR.—Not later than 10 days after the date of receipt of a report submitted by a chain under paragraph (1), an independent monitor shall finalize its recommendations and submit a report to the chain and facilities of the chain, the Secretary, and the State (or States) involved, as appropriate, containing such final recommendations.

(e) COST OF APPOINTMENT.—A chain shall be responsible for a portion of the costs associated with the appointment of independent monitors under the pilot program. The chain shall pay such portion to the Secretary (in an amount and in accordance with procedures established by the Secretary).

(f) WAIVER AUTHORITY.—The Secretary may waive such requirements of titles XVIII and XIX of the Social Security Act (42 U.S.C. 1395 et seq.; 1396 et seq.) as may be necessary for the purpose of carrying out the pilot program.

(g) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as may be necessary to carry out this section.

(h) DEFINITIONS.—In this section:

(1) FACILITY.—The term ''facility'' means a skilled nursing facility or a nursing facility.

(2) NURSING FACILITY.—The term ''nursing facility'' has the meaning given such term in section 1919(a) of the Social Security Act (42 U.S.C. 1396r(a)).

(3) SECRETARY.—The term ''Secretary'' means the Secretary of Health and Human Services, acting through the Assistant Secretary for Planning and Evaluation.

(4) SKILLED NURSING FACILITY.—The term ''skilled nursing facility'' has the meaning given such term in section 1819(a) of the Social Security Act (42 U.S.C. 1395(a)).

(i) EVALUATION AND REPORT.—

(1) EVALUATION.—The Inspector General of the Department of Health and Human Services shall evaluate the pilot program. Such evaluation shall—

(A) determine whether the independent monitor program should be established on a permanent basis; and

(B) if the Inspector General determines that the independent monitor program should be established on a permanent basis, recommend appropriate procedures and mechanisms for such establishment.

(2) REPORT.—Not later than 180 days after the completion of the pilot program, the Inspector General shall submit to Congress and the Secretary a report containing the results of the evaluation conducted under paragraph (1), together with recommendations for such legislation and administrative action as the Inspector General determines appropriate.

SEC. 1423. NOTIFICATION OF FACILITY CLOSURE.

(a) SKILLED NURSING FACILITIES.—

(1) IN GENERAL.—Section 1819(c) of the Social Security Act (42 U.S.C. 1395i–3(c)) is amended by adding at the end the following new paragraph:

''(7) NOTIFICATION OF FACILITY CLOSURE.—

''(A) IN GENERAL.—Any individual who is the administrator of a skilled nursing facility must—

''(i) submit to the Secretary, the State long-term care ombudsman, residents of the facility, and the legal representatives of such residents or other responsible parties, written notification of an impending closure—

''(I) subject to subclause (II), not later than the date that is 60 days prior to the date of such closure; and

''(II) in the case of a facility where the Secretary terminates the facility's participation under this title, not later than the date that the Secretary determines appropriate;

''(ii) ensure that the facility does not admit any new residents on or after the date on which such written notification is submitted; and

''(iii) include in the notice a plan for the transfer and adequate relocation of the residents of the facility by a specified date prior to closure that has been approved by the State, including assurances that the residents will be transferred to the most appropriate facility or other setting in terms of quality, services, and location, taking into consideration the needs and best interests of each resident.

''(B) RELOCATION.—

''(i) IN GENERAL.—The State shall ensure that, before a facility closes, all

residents of the facility have been successfully relocated to another facility or an alternative home and community-based setting.

''(ii) CONTINUATION OF PAYMENTS UNTIL RESIDENTS RELOCATED.—The Secretary may, as the Secretary determines appropriate, continue to make payments under this title with respect to residents of a facility that has submitted a notification under subparagraph (A) during the period beginning on the date such notification is submitted and ending on the date on which the resident is successfully relocated.''.

(2) CONFORMING AMENDMENTS.—Section 1819(h)(4) of the Social Security Act (42 U.S.C. 1395i–3(h)(4)) is amended—

(A) in the first sentence, by striking ''the Secretary shall terminate'' and inserting ''the Secretary, subject to subsection (c)(7), shall terminate''; and

(B) in the second sentence, by striking ''subsection (c)(2)'' and inserting ''paragraphs (2) and (7) of subsection (c)''.

(b) NURSING FACILITIES.—

(1) IN GENERAL.—Section 1919(c) of the Social Security Act (42 U.S.C. 1396r(c)) is amended by adding at the end the following new paragraph:

''(9) NOTIFICATION OF FACILITY CLOSURE.—

''(A) IN GENERAL.—Any individual who is an administrator of a nursing facility must—

''(i) submit to the Secretary, the State long-term care ombudsman, residents of the facility, and the legal representatives of such residents or other responsible parties, written notification of an impending closure—

''(I) subject to subclause (II), not later than the date that is 60 days prior to the date of such closure; and

''(II) in the case of a facility where the Secretary terminates the facility's participation under this title, not later than the date that the Secretary determines appropriate;

''(ii) ensure that the facility does not admit any new residents on or after the date on which such written notification is submitted; and

''(iii) include in the notice a plan for the transfer and adequate relocation of the residents of the facility by a specified date prior to closure that has been approved by the State, including assurances that the residents will be transferred to the most appropriate facility or other setting in terms of quality, services, and location, taking into consideration the needs and best interests of each resident.

''(B) RELOCATION.—

''(i) IN GENERAL.—The State shall ensure that, before a facility closes, all residents of the facility have been successfully relocated to another facility or an alternative home and community-based setting.

''(ii) CONTINUATION OF PAYMENTS UNTIL RESIDENTS RELOCATED.—The Secretary may, as the Secretary determines appropriate, continue to make payments under this title with respect to residents of a facility that has submitted a notification under subparagraph (A) during the period beginning on the date such notification is

submitted and ending on the date on which the resident is successfully relocated.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall take effect 1 year after the date of the enactment of this Act.

PART 3—IMPROVING STAFF TRAINING

SEC. 1431. DEMENTIA AND ABUSE PREVENTION TRAINING.

(a) SKILLED NURSING FACILITIES.—Section 1819(f)(2)(A)(i)(I) of the Social Security Act (42 U.S.C. 1395i–3(f)(2)(A)(i)(I)) is amended by inserting ''(including, in the case of initial training and, if the Secretary determines appropriate, in the case of ongoing training, dementia management training and resident abuse prevention training)'' after ''curriculum''.

(b) NURSING FACILITIES.—Section 1919(f)(2)(A)(i)(I) of the Social Security Act (42 U.S.C. 1396r(f)(2)(A)(i)(I)) is amended by inserting ''(including, in the case of initial training and, if the Secretary determines appropriate, in the case of ongoing training, dementia management training and resident abuse prevention training)'' after ''curriculum''.

(c) EFFECTIVE DATE.—The amendments made by this section shall take effect 1 year after the date of the enactment of this Act.

SEC. 1432. STUDY AND REPORT ON TRAINING REQUIRED FOR CERTIFIED NURSE AIDES AND SUPERVISORY STAFF.

(a) STUDY.—

(1) IN GENERAL.—The Secretary shall conduct a study on the content of training for certified nurse aides and supervisory staff of skilled nursing facilities and nursing facilities. The study shall include an analysis of the following:

(A) Whether the number of initial training hours for certified nurse aides required under sections 1819(f)(2)(A)(i)(II) and 1919(f)(2)(A)(i)(II) of the Social Security Act (42 U.S.C. 1395i–3(f)(2)(A)(i)(II); 1396r(f)(2)(A)(i)(II)) should be increased from 75 and, if so, what the required number of initial training hours should be, including any recommendations for the content of such training (including training related to dementia).

(B) Whether requirements for ongoing training under such sections 1819(f)(2)(A)(i)(II) and 1919(f)(2)(A)(i)(II) should be increased from 12 hours per year, including any recommendations for the content of such training.

(2) CONSULTATION.—In conducting the analysis under paragraph (1)(A), the Secretary shall consult with States that, as of the date of the enactment of this Act, require more than 75 hours of training for certified nurse aides.

(3) DEFINITIONS.—In this section:

(A) NURSING FACILITY.—The term ''nursing facility'' has the meaning given such term in section 1919(a) of the Social Security Act (42 U.S.C. 1396r(a)).

(B) SECRETARY.—The term ''Secretary'' means the Secretary of Health and Human Services, acting through the Assistant Secretary for Planning and Evaluation.

(C) SKILLED NURSING FACILITY.—The term ''skilled nursing facility'' has the meaning given such term in section 1819(a) of the Social Security Act (42 U.S.C. 1395(a)).

(b) REPORT.—Not later than 2 years after the date of the enactment of this Act, the Secretary shall submit to Congress a report containing the results of the study conducted under subsection (a), together with recommendations for such legislation and administrative action as the Secretary determines appropriate.

Subtitle C—Quality Measurements

SEC. 1441. ESTABLISHMENT OF NATIONAL PRIORITIES FOR QUALITY IMPROVEMENT.

Title XI of the Social Security Act, as amended by section 1401(a), is further amended by adding at the end the following new part:

''PART E—QUALITY IMPROVEMENT

''ESTABLISHMENT OF NATIONAL PRIORITIES FOR PERFORMANCE IMPROVEMENT

''SEC. 1191. (a) ESTABLISHMENT OF NATIONAL PRIORITIES BY THE SECRETARY.—The Secretary shall establish and periodically update, not less frequently than triennially, national priorities for performance improvement.

''(b) RECOMMENDATIONS FOR NATIONAL PRIORITIES.—In establishing and updating national priorities under subsection (a), the Secretary shall solicit and consider recommendations from multiple outside stakeholders.

''(c) CONSIDERATIONS IN SETTING NATIONAL PRIORITIES.—With respect to such priorities, the Secretary shall ensure that priority is given to areas in the delivery of health care services in the United States that—

''(1) contribute to a large burden of disease, including those that address the health care provided

to patients with prevalent, high-cost chronic diseases;

''(2) have the greatest potential to decrease morbidity and mortality in this country, including those that are designed to eliminate harm to patients;

''(3) have the greatest potential for improving the performance, affordability, and patient-centeredness of health care, including those due to variations in care;

''(4) address health disparities across groups and areas; and

''(5) have the potential for rapid improvement due to existing evidence, standards of care or other reasons.

''(d) DEFINITIONS.—In this part:

''(1) CONSENSUS-BASED ENTITY.—The term 'consensus-based entity' means an entity with a contract with the Secretary under section 1890.

''(2) QUALITY MEASURE.—The term 'quality measure' means a national consensus standard for measuring the performance and improvement of population health, or of institutional providers of services, physicians, and other health care practitioners in the delivery of health care services.

''(e) FUNDING.—

''(1) IN GENERAL.—The Secretary shall provide for the transfer, from the Federal Hospital Insurance Trust Fund under section 1817 and the Federal Supplementary Medical Insurance Trust Fund under section 1841 (in such proportion as the Secretary determines appropriate), of $2,000,000, for the activities under this section for each of the fiscal years 2010 through 2014.

''(2) AUTHORIZATION OF APPROPRIATIONS.—For purposes of carrying out the provisions of this section, in addition to funds otherwise available, out of any funds in the Treasury not otherwise appropriated, there are appropriated to the Secretary of Health and Human Services $2,000,000 for each of the fiscal years 2010 through 2014.''.

SEC. 1442. DEVELOPMENT OF NEW QUALITY MEASURES; GAO EVALUATION OF DATA COLLECTION PROCESS FOR QUALITY MEASUREMENT.

Part E of title XI of the Social Security Act, as added by section 1441, is amended by adding at the end the following new sections:

''**SEC. 1192. DEVELOPMENT OF NEW QUALITY MEASURES.**

''(a) AGREEMENTS WITH QUALIFIED ENTITIES.—

''(1) IN GENERAL.—The Secretary shall enter into agreements with qualified entities to develop quality measures for the delivery of health care services in the United States.

''(2) FORM OF AGREEMENTS.—The Secretary may carry out paragraph (1) by contract, grant, or otherwise.

''(3) RECOMMENDATIONS OF CONSENSUS-BASED ENTITY.—In carrying out this section, the Secretary shall—

''(A) seek public input; and

''(B) take into consideration recommendations of the consensus-based entity with a contract with the Secretary under section 1890(a).

''(b) DETERMINATION OF AREAS WHERE QUALITY MEASURES ARE REQUIRED.—Consistent with the national priorities established under this part and with the programs administered by the Centers for Medicare & Medicaid Services and in consultation with other relevant Federal agencies, the Secretary shall determine areas in which quality measures for assessing health care services in the United States are needed.

''(c) DEVELOPMENT OF QUALITY MEASURES.—

''(1) PATIENT-CENTERED AND POPULATION-BASED MEASURES.—Quality measures developed

under agreements under subsection (a) shall be designed—

''(A) to assess outcomes and functional status of patients;

''(B) to assess the continuity and coordination of care and care transitions for patients across providers and health care settings, including end of life care;

''(C) to assess patient experience and patient engagement;

''(D) to assess the safety, effectiveness, and timeliness of care;

''(E) to assess health disparities including those associated with individual race, ethnicity, age, gender, place of residence or language;

''(F) to assess the efficiency and resource use in the provision of care;

''(G) to the extent feasible, to be collected as part of health information technologies supporting better delivery of health care services;

''(H) to be available free of charge to users for the use of such measures; and

''(I) to assess delivery of health care services to individuals regardless of age.

''(2) AVAILABILITY OF MEASURES.—The Secretary shall make quality measures developed under this section available to the public.

''(3) TESTING OF PROPOSED MEASURES.—The Secretary may use amounts made available under subsection (f) to fund the testing of proposed quality measures by qualified entities. Testing funded under this paragraph shall include testing of the feasibility and usability of proposed measures.

''(4) UPDATING OF ENDORSED MEASURES.—The Secretary may use amounts made available under subsection (f) to fund the updating (and testing, if applicable) by consensus-based entities of quality measures that have been previously endorsed by such an entity as new evidence is developed, in a manner consistent with section 1890(b)(3).

''(d) QUALIFIED ENTITIES.—Before entering into agreements with a qualified entity, the Secretary shall ensure that the entity is a public, nonprofit or academic institution with technical expertise in the area of health quality measurement.

''(e) APPLICATION FOR GRANT.—A grant may be made under this section only if an application for the grant is submitted to the Secretary and the application is in such form, is made in such manner, and contains

such agreements, assurances, and information as the Secretary determines to be necessary to carry out this section.

''(f) FUNDING.—

''(1) IN GENERAL.—The Secretary shall provide for the transfer, from the Federal Hospital Insurance Trust Fund under section 1817 and the Federal Supplementary Medical Insurance Trust Fund under section 1841 (in such proportion as the Secretary determines appropriate), of $25,000,000, to the Secretary for purposes of carrying out this section for each of the fiscal years 2010 through 2014.

''(2) AUTHORIZATION OF APPROPRIATIONS.—For purposes of carrying out the provisions of this section, in addition to funds otherwise available, out of any funds in the Treasury not otherwise appropriated, there are appropriated to the Secretary of Health and Human Services $25,000,000 for each of the fiscal years 2010 through 2014.

''SEC. 1193. GAO EVALUATION OF DATA COLLECTION PROCESS FOR QUALITY MEASUREMENT.

''(a) GAO EVALUATIONS.—The Comptroller General of the United States shall conduct periodic evaluations of the implementation of the data collection processes for quality measures used by the Secretary.

''(b) CONSIDERATIONS.—In carrying out the evaluation under subsection (a), the Comptroller General shall determine—

''(1) whether the system for the collection of data for quality measures provides for validation of data as relevant and scientifically credible;

''(2) whether data collection efforts under the system use the most efficient and cost-effective means in a manner that minimizes administrative burden on persons required to collect data and that adequately protects the privacy of patients' personal health information and provides data security;

''(3) whether standards under the system provide for an appropriate opportunity for physicians and other clinicians and institutional providers of services to review and correct findings; and

''(4) the extent to which quality measures are consistent with section 1192(c)(1) or result in direct or indirect costs to users of such measures.

''(c) REPORT.—The Comptroller General shall submit reports to Congress and to the Secretary containing a description of the findings and conclusions of the results of each such evaluation.''.

SEC. 1443. MULTI-STAKEHOLDER PRE-RULEMAKING INPUT INTO SELECTION OF QUALITY MEASURES.

Section 1808 of the Social Security Act (42 U.S.C. 1395b–9) is amended by adding at the end the following new subsection:

''(d) MULTI-STAKEHOLDER PRE-RULEMAKING INPUT INTO SELECTION OF QUALITY MEASURES.—

''(1) LIST OF MEASURES.—Not later than December 1 before each year (beginning with 2011), the Secretary shall make public a list of measures being considered for selection for quality measurement by the Secretary in rulemaking with respect to payment systems under this title beginning in the payment year beginning in such year and for payment systems beginning in the calendar year following such year, as the case may be.

''(2) CONSULTATION ON SELECTION OF ENDORSED QUALITY MEASURES.—A consensus-based entity that has entered into a contract under section 1890 shall, as part of such contract, convene multi-stakeholder groups to provide recommendations on the selection of individual or composite quality measures, for use in reporting performance information to the public or for use in public health care programs.

''(3) MULTI-STAKEHOLDER INPUT.—Not later than February 1 of each year (beginning with 2011), the consensus-based entity described in paragraph (2) shall transmit to the Secretary the recommendations of multi-stakeholder groups provided under paragraph (2). Such recommendations shall be included in the transmissions the consensus-based entity makes to the Secretary under the contract provided for under section 1890.

''(4) REQUIREMENT FOR TRANSPARENCY IN PROCESS.—

''(A) IN GENERAL.—In convening multi-stakeholder groups under paragraph (2) with respect to the selection of quality measures, the consensus-based entity described in such paragraph shall provide for an open and transparent process for the activities conducted pursuant to such convening.

''(B) SELECTION OF ORGANIZATIONS PARTICIPATING IN MULTI-STAKEHOLDER GROUPS.—The process under paragraph (2) shall ensure that the selection of representatives of multi-stakeholder groups includes provision for public nominations for, and the opportunity for public comment on, such selection.

''(5) USE OF INPUT.—The respective proposed rule shall contain a summary of the recommendations made by the multi-stakeholder groups under paragraph (2), as well as other comments received regarding the proposed measures, and the extent to which such proposed rule follows such recommendations and the rationale for not following such recommendations.

''(6) MULTI-STAKEHOLDER GROUPS.—For purposes of this subsection, the term 'multi-stakeholder groups' means, with respect to a quality measure, a voluntary collaborative of organizations representing persons interested in or affected by the use of such quality measure, such as the following:

''(A) Hospitals and other institutional providers.

''(B) Physicians.

''(C) Health care quality alliances.

''(D) Nurses and other health care practitioners.

''(E) Health plans.

''(F) Patient advocates and consumer groups.

''(G) Employers.

''(H) Public and private purchasers of health care items and services.

''(I) Labor organizations.

''(J) Relevant departments or agencies of the United States.

''(K) Biopharmaceutical companies and manufacturers of medical devices.

''(L) Licensing, credentialing, and accrediting bodies.

''(7) FUNDING.—

''(A) IN GENERAL.—The Secretary shall provide for the transfer, from the Federal Hospital Insurance Trust Fund under section 1817 and the Federal Supplementary Medical Insurance Trust Fund under section 1841 (in such proportion as the Secretary determines appropriate), of $1,000,000, to the Secretary for purposes of carrying out this subsection for each of the fiscal years 2010 through 2014.

''(B) AUTHORIZATION OF APPROPRIATIONS.—For purposes of carrying out the provisions of this subsection, in addition to funds otherwise available, out of any funds in the Treasury not otherwise appropriated, there are appropriated to the Secretary of Health and

Human Services $1,000,000 for each of the fiscal years 2010 through 2014.''.

SEC. 1444. APPLICATION OF QUALITY MEASURES.

(a) INPATIENT HOSPITAL SERVICES.—Section 1886(b)(3)(B) of such Act (42 U.S.C. 1395ww(b)(3)(B)) is amended by adding at the end the following new clause:

''(x)(I) Subject to subclause (II), for purposes of reporting data on quality measures for inpatient hospital services furnished during fiscal year 2012 and each subsequent fiscal year, the quality measures specified under clause (viii) shall be measures selected by the Secretary from measures that have been endorsed by the entity with a contract with the Secretary under section 1890(a).

''(II) In the case of a specified area or medical topic determined appropriate by the Secretary for which a feasible and practical quality measure has not been endorsed by the entity with a contract under section 1890(a), the Secretary may specify a measure that is not so endorsed as long as due consideration is given to measures that have been endorsed or adopted by a consensus organization identified by the Secretary. The Secretary shall submit such a non-endorsed measure to the entity for consideration for endorsement. If the entity considers but does not endorse such a measure and if the Secretary does not phase-out use of such measure, the Secretary shall include

the rationale for continued use of such a measure in rulemaking.''.

(b) OUTPATIENT HOSPITAL SERVICES.—Section 1833(t)(17) of such Act (42 U.S.C. 1395l(t)(17)) is amended by adding at the end the following new subparagraph:

''(F) USE OF ENDORSED QUALITY MEASURES.—The provisions of clause (x) of section 1886(b)(3)(C) shall apply to quality measures for covered OPD services under this paragraph in the same manner as such provisions apply to quality measures for inpatient hospital services.''.

(c) PHYSICIANS' SERVICES.—Section 1848(k)(2)(C)(ii) of such Act (42 U.S.C. 1395w-4(k)(2)(C)(ii)) is amended by adding at the end the following: ''The Secretary shall submit such a non-endorsed measure to the entity for consideration for endorsement. If the entity considers but does not endorse such a measure and if the Secretary does not phase-out use of such measure, the Secretary shall include the rationale for continued use of such a measure in rulemaking.''.''.

(d) RENAL DIALYSIS SERVICES.—Section 1881(h)(2)(B)(ii) of such Act (42 U.S.C. 1395rr(h)(2)(B)(ii)) is amended by adding at the end the

following: ''The Secretary shall submit such a non-endorsed measure to the entity for consideration for endorsement. If the entity considers but does not endorse such a measure and if the Secretary does not phase-out use of such measure, the Secretary shall include the rationale for continued use of such a measure in rulemaking.''.

(e) ENDORSEMENT OF STANDARDS.—Section 1890(b)(2) of the Social Security Act (42 U.S.C. 1395aaa(b)(2)) is amended by adding after and below subparagraph (B) the following:

'' 'If the entity does not endorse a measure, such entity shall explain the reasons and provide suggestions about changes to such measure that might make it a potentially endorsable measure.' ''.

(f) EFFECTIVE DATE.—Except as otherwise provided, the amendments made by this section shall apply to quality measures applied for payment years beginning with 2012 or fiscal year 2012, as the case may be.

SEC. 1445. CONSENSUS-BASED ENTITY FUNDING.

Section 1890(d) of the Social Security Act (42 U.S.C. 1395aaa(d)) is amended by striking ''for each of fiscal years 2009 through 2012'' and inserting ''for fiscal year 2009, and $12,000,000 for each of the fiscal years 2010 through 2012.''

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.

(a) IN GENERAL.—Part A of title XI of the Social Security Act (42 U.S.C. 1301 et seq.), as amended by section 1631(a), is further amended by inserting after section 1128G the following new section:

"**SEC. 1128H. FINANCIAL REPORTS ON PHYSICIANS' FINANCIAL RELATIONSHIPS WITH MANUFACTURERS AND DISTRIBUTORS OF COVERED DRUGS, DEVICES, BIOLOGICALS, OR MEDICAL SUPPLIES UNDER MEDICARE, MEDICAID, OR CHIP AND WITH ENTITIES THAT BILL FOR SERVICES UNDER MEDICARE.**

"(a) REPORTING OF PAYMENTS OR OTHER TRANSFERS OF VALUE.—

"(1) IN GENERAL.—Except as provided in this subsection, not later than March 31, 2011 and an-

nually thereafter, each applicable manufacturer or distributor that provides a payment or other transfer of value to a covered recipient, or to an entity or individual at the request of or designated on behalf of a covered recipient, shall submit to the Secretary, in such electronic form as the Secretary shall require, the following information with respect to the preceding calendar year:

''(A) With respect to the covered recipient, the recipient's name, business address, physician specialty, and national provider identifier.

''(B) With respect to the payment or other transfer of value, other than a drug sample—

''(i) its value and date;

''(ii) the name of the related drug, device, or supply, if available; and

''(iii) a description of its form, indicated (as appropriate for all that apply) as—

''(I) cash or a cash equivalent;

''(II) in-kind items or services;

''(III) stock, a stock option, or any other ownership interest, dividend, profit, or other return on investment; or

''(IV) any other form (as defined by the Secretary).

''(C) With respect to a drug sample, the name, number, date, and dosage units of the sample.

''(2) AGGREGATE REPORTING.—Information submitted by an applicable manufacturer or distributor under paragraph (1) shall include the aggregate amount of all payments or other transfers of value provided by the manufacturer or distributor to covered recipients (and to entities or individuals at the request of or designated on behalf of a covered recipient) during the year involved, including all payments and transfers of value regardless of whether such payments or transfer of value were individually disclosed.

''(3) SPECIAL RULE FOR CERTAIN PAYMENTS OR OTHER TRANSFERS OF VALUE.—In the case where an applicable manufacturer or distributor provides a payment or other transfer of value to an entity or individual at the request of or designated on behalf of a covered recipient, the manufacturer or distributor shall disclose that payment or other transfer of value under the name of the covered recipient.

''(4) DELAYED REPORTING FOR PAYMENTS MADE PURSUANT TO PRODUCT DEVELOPMENT AGREEMENTS.—In the case of a payment or other transfer of value made to a covered recipient by an applicable manufacturer or distributor pursuant to a product development agreement for services furnished in connection with the development of a new drug, device, biological, or medical supply, the applicable manufacturer or distributor may report the value and recipient of such payment or other transfer of value in the first reporting period under this subsection in the next reporting deadline after the earlier of the following:

''(A) The date of the approval or clearance of the covered drug, device, biological, or medical supply by the Food and Drug Administration.

''(B) Two calendar years after the date such payment or other transfer of value was made.

''(5) DELAYED REPORTING FOR PAYMENTS MADE PURSUANT TO CLINICAL INVESTIGATIONS.—In the case of a payment or other transfer of value made to a covered recipient by an applicable manufacturer or distributor in connection with a clinical

investigation regarding a new drug, device, biological, or medical supply, the applicable manufacturer or distributor may report as required under this section in the next reporting period under this subsection after the earlier of the following:

''(A) The date that the clinical investigation is registered on the website maintained by the National Institutes of Health pursuant to section 671 of the Food and Drug Administration Amendments Act of 2007.

''(B) Two calendar years after the date such payment or other transfer of value was made.

''(6) CONFIDENTIALITY.—Information described in paragraph (4) or (5) shall be considered confidential and shall not be subject to disclosure under section 552 of title 5, United States Code, or any other similar Federal, State, or local law, until or after the date on which the information is made available to the public under such paragraph.

''(b) REPORTING OF OWNERSHIP INTEREST BY PHYSICIANS IN HOSPITALS AND OTHER ENTITIES THAT BILL MEDICARE.—Not later than March 31 of each year (beginning with 2011), each hospital or other health care entity (not including a Medicare Advantage organization)

that bills the Secretary under part A or part B of title XVIII for services shall report on the ownership shares (other than ownership shares described in section 1877(c)) of each physician who, directly or indirectly, owns an interest in the entity. In this subsection, the term 'physician' includes a physician's immediate family members (as defined for purposes of section 1877(a)).

''(c) PUBLIC AVAILABILITY.—

''(1) IN GENERAL.—The Secretary shall establish procedures to ensure that, not later than September 30, 2011, and on June 30 of each year beginning thereafter, the information submitted under subsections (a) and (b), other than information regard drug samples, with respect to the preceding calendar year is made available through an Internet website that—

''(A) is searchable and is in a format that is clear and understandable;

''(B) contains information that is presented by the name of the applicable manufacturer or distributor, the name of the covered recipient, the business address of the covered recipient, the specialty (if applicable) of the covered recipient, the value of the payment or other transfer of value, the date on which the

payment or other transfer of value was provided to the covered recipient, the form of the payment or other transfer of value, indicated (as appropriate) under subsection (a)(1)(B)(ii), the nature of the payment or other transfer of value, indicated (as appropriate) under subsection (a)(1)(B)(iii), and the name of the covered drug, device, biological, or medical supply, as applicable;

''(C) contains information that is able to be easily aggregated and downloaded;

''(D) contains a description of any enforcement actions taken to carry out this section, including any penalties imposed under subsection (d), during the preceding year;

''(E) contains background information on industry-physician relationships;

''(F) in the case of information submitted with respect to a payment or other transfer of value described in subsection (a)(5), lists such information separately from the other information submitted under subsection (a) and designates such separately listed information as funding for clinical research;

''(G) contains any other information the Secretary determines would be helpful to the average consumer; and

''(H) provides the covered recipient an opportunity to submit corrections to the information made available to the public with respect to the covered recipient.

''(2) ACCURACY OF REPORTING.—The accuracy of the information that is submitted under subsections (a) and (b) and made available under paragraph (1) shall be the responsibility of the applicable manufacturer or distributor of a covered drug, device, biological, or medical supply reporting under subsection (a) or hospital or other health care entity reporting physician ownership under subsection (b). The Secretary shall establish procedures to ensure that the covered recipient is provided with an opportunity to submit corrections to the manufacturer, distributor, hospital, or other entity reporting under subsection (a) or (b) with regard to information made public with respect to the covered recipient and, under such procedures, the corrections shall be transmitted to the Secretary.

''(3) SPECIAL RULE FOR DRUG SAMPLES.—Information relating to drug samples provided under

subsection (a) shall not be made available to the public by the Secretary but may be made available outside the Department of Health and Human Services by the Secretary for research or legitimate business purposes pursuant to data use agreements.

''(4) SPECIAL RULE FOR NATIONAL PROVIDER IDENTIFIERS.—Information relating to national provider identifiers provided under subsection (a) shall not be made available to the public by the Secretary but may be made available outside the Department of Health and Human Services by the Secretary for research or legitimate business purposes pursuant to data use agreements.

''(d) PENALTIES FOR NONCOMPLIANCE.—

''(1) FAILURE TO REPORT.—

''(A) IN GENERAL.—Subject to subparagraph (B), except as provided in paragraph (2), any applicable manufacturer or distributor that fails to submit information required under subsection (a) in a timely manner in accordance with regulations promulgated to carry out such subsection, and any hospital or other entity that fails to submit information required under subsection (b) in a timely manner in accordance with regulations promulgated to carry out such

subsection shall be subject to a civil money penalty of not less than $1,000, but not more than $10,000, for each payment or other transfer of value or ownership or investment interest not reported as required under such subsection. Such penalty shall be imposed and collected in the same manner as civil money penalties under subsection (a) of section 1128A are imposed and collected under that section.

''(B) LIMITATION.—The total amount of civil money penalties imposed under subparagraph (A) with respect to each annual submission of information under subsection (a) by an applicable manufacturer or distributor or other entity shall not exceed $150,000.

''(2) KNOWING FAILURE TO REPORT.—

''(A) IN GENERAL.—Subject to subparagraph (B), any applicable manufacturer or distributor that knowingly fails to submit information required under subsection (a) in a timely manner in accordance with regulations promulgated to carry out such subsection and any hospital or other entity that fails to submit information required under subsection (b) in a timely manner in accordance with regulations pro-

mulgated to carry out such subsection, shall be subject to a civil money penalty of not less than $10,000, but not more than $100,000, for each payment or other transfer of value or ownership or investment interest not reported as required under such subsection. Such penalty shall be imposed and collected in the same manner as civil money penalties under subsection (a) of section 1128A are imposed and collected under that section.

''(B) LIMITATION.—The total amount of civil money penalties imposed under subparagraph (A) with respect to each annual submission of information under subsection (a) or (b) by an applicable manufacturer, distributor, or entity shall not exceed $1,000,000, or, if greater, 0.1 percentage of the total annual revenues of the manufacturer, distributor, or entity.

''(3) USE OF FUNDS.—Funds collected by the Secretary as a result of the imposition of a civil money penalty under this subsection shall be used to carry out this section.

''(4) ENFORCEMENT THROUGH STATE ATTORNEYS GENERAL.—The attorney general of a State, after providing notice to the Secretary of an intent

to proceed under this paragraph in a specific case and providing the Secretary with an opportunity to bring an action under this subsection and the Secretary declining such opportunity, may proceed under this subsection against a manufacturer or distributor in the State.

''(e) ANNUAL REPORT TO CONGRESS.—Not later than April 1 of each year beginning with 2011, the Secretary shall submit to Congress a report that includes the following:

''(1) The information submitted under this section during the preceding year, aggregated for each applicable manufacturer or distributor of a covered drug, device, biological, or medical supply that submitted such information during such year.

''(2) A description of any enforcement actions taken to carry out this section, including any penalties imposed under subsection (d), during the preceding year.

''(f) DEFINITIONS.—In this section:

''(1) APPLICABLE MANUFACTURER; APPLICABLE DISTRIBUTOR.—The term 'applicable manufacturer' means a manufacturer of a covered drug, device, biological, or medical supply, and the term 'ap-

plicable distributor' means a distributor of a covered drug, device, or medical supply.

''(2) CLINICAL INVESTIGATION.—The term 'clinical investigation' means any experiment involving one or more human subjects, or materials derived from human subjects, in which a drug or device is administered, dispensed, or used.

''(3) COVERED DRUG, DEVICE, BIOLOGICAL, OR MEDICAL SUPPLY.—The term 'covered' means, with respect to a drug, device, biological, or medical supply, such a drug, device, biological, or medical supply for which payment is available under title XVIII or a State plan under title XIX or XXI (or a waiver of such a plan).

''(4) COVERED RECIPIENT.—The term 'covered recipient' means the following:

''(A) A physician.

''(B) A physician group practice.

''(C) Any other prescriber of a covered drug, device, biological, or medical supply.

''(D) A pharmacy or pharmacist.

''(E) A health insurance issuer, group health plan, or other entity offering a health benefits plan, including any employee of such an issuer, plan, or entity.

''(F) A pharmacy benefit manager, including any employee of such a manager.

''(G) A hospital.

''(H) A medical school.

''(I) A sponsor of a continuing medical education program.

''(J) A patient advocacy or disease specific group.

''(K) A organization of health care professionals.

''(L) A biomedical researcher.

''(M) A group purchasing organization.

''(5) DISTRIBUTOR OF A COVERED DRUG, DEVICE, OR MEDICAL SUPPLY.—The term 'distributor of a covered drug, device, or medical supply' means any entity which is engaged in the marketing or distribution of a covered drug, device, or medical supply (or any subsidiary of or entity affiliated with such entity), but does not include a wholesale pharmaceutical distributor.

''(6) EMPLOYEE.—The term 'employee' has the meaning given such term in section 1877(h)(2).

''(7) KNOWINGLY.—The term 'knowingly' has the meaning given such term in section 3729(b) of title 31, United States Code.

''(8) MANUFACTURER OF A COVERED DRUG, DEVICE, BIOLOGICAL, OR MEDICAL SUPPLY.—The term 'manufacturer of a covered drug, device, biological, or medical supply' means any entity which is engaged in the production, preparation, propagation, compounding, conversion, processing, marketing, or distribution of a covered drug, device, biological, or medical supply (or any subsidiary of or entity affiliated with such entity).

''(9) PAYMENT OR OTHER TRANSFER OF VALUE.—

''(A) IN GENERAL.—The term 'payment or other transfer of value' means a transfer of anything of value for or of any of the following:

''(i) Gift, food, or entertainment.

''(ii) Travel or trip.

''(iii) Honoraria.

''(iv) Research funding or grant.

''(v) Education or conference funding.

''(vi) Consulting fees.

''(vii) Ownership or investment interest and royalties or license fee.

''(B) INCLUSIONS.—Subject to subparagraph (C), the term 'payment or other transfer of value' includes any compensation, gift, hono-

rarium, speaking fee, consulting fee, travel, services, dividend, profit distribution, stock or stock option grant, or any ownership or investment interest held by a physician in a manufacturer (excluding a dividend or other profit distribution from, or ownership or investment interest in, a publicly traded security or mutual fund (as described in section 1877(c))).

''(C) EXCLUSIONS.—The term 'payment or other transfer of value' does not include the following:

''(i) Any payment or other transfer of value provided by an applicable manufacturer or distributor to a covered recipient where the amount transferred to, requested by, or designated on behalf of the covered recipient does not exceed $5.

''(ii) The loan of a covered device for a short-term trial period, not to exceed 90 days, to permit evaluation of the covered device by the covered recipient.

''(iii) Items or services provided under a contractual warranty, including the replacement of a covered device, where the terms of the warranty are set forth in the

purchase or lease agreement for the covered device.

''(iv) A transfer of anything of value to a covered recipient when the covered recipient is a patient and not acting in the professional capacity of a covered recipient.

''(v) In-kind items used for the provision of charity care.

''(vi) A dividend or other profit distribution from, or ownership or investment interest in, a publicly traded security and mutual fund (as described in section 1877(c)).

''(vii) Compensation paid by a manufacturer or distributor of a covered drug, device, biological, or medical supply to a covered recipient who is directly employed by and works solely for such manufacturer or distributor.

''(viii) Any discount or cash rebate.

''(10) PHYSICIAN.—The term 'physician' has the meaning given that term in section 1861(r). For purposes of this section, such term does not include a physician who is an employee of the applicable

manufacturer that is required to submit information under subsection (a).

''(g) ANNUAL REPORTS TO STATES.—Not later than April 1 of each year beginning with 2011, the Secretary shall submit to States a report that includes a summary of the information submitted under subsections (a) and (d) during the preceding year with respect to covered recipients or other hospitals and entities in the State.

''(h) RELATION TO STATE LAWS.—

''(1) IN GENERAL.—Effective on January 1, 2011, subject to paragraph (2), the provisions of this section shall preempt any law or regulation of a State or of a political subdivision of a State that requires an applicable manufacturer and applicable distributor (as such terms are defined in subsection (f)) to disclose or report, in any format, the type of information (described in subsection (a)) regarding a payment or other transfer of value provided by the manufacturer to a covered recipient (as so defined).

''(2) NO PREEMPTION OF ADDITIONAL REQUIREMENTS.—Paragraph (1) shall not preempt any law or regulation of a State or of a political subdivision of a State that requires any of the following:

''(A) The disclosure or reporting of information not of the type required to be disclosed or reported under this section.

''(B) The disclosure or reporting, in any format, of the type of information required to be disclosed or reported under this section to a Federal, State, or local governmental agency for public health surveillance, investigation, or other public health purposes or health oversight purposes.

''(C) The discovery or admissibility of information described in this section in a criminal, civil, or administrative proceeding.''.

(b) AVAILABILITY OF INFORMATION FROM THE DISCLOSURE OF FINANCIAL RELATIONSHIP REPORT (DFRR).—The Secretary of Health and Human Services shall submit to Congress a report on the full results of the Disclosure of Physician Financial Relationships surveys required pursuant to section 5006 of the Deficit Reduction Act of 2005. Such report shall be submitted to Congress not later than the date that is 6 months after the date such surveys are collected and shall be made publicly available on an Internet website of the Department of Health and Human Services.

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.

(a) IN GENERAL.—Title XI of the Social Security Act is amended by inserting after section 1138 the following section:

"**SEC. 1138A. REQUIREMENT FOR PUBLIC REPORTING BY HOSPITALS AND AMBULATORY SURGICAL CENTERS ON HEALTH CARE-ASSOCIATED INFECTIONS.**

"(a) REPORTING REQUIREMENT.—

"(1) IN GENERAL.—The Secretary shall provide that a hospital (as defined in subsection (g)) or ambulatory surgical center meeting the requirements of titles XVIII or XIX may participate in the programs established under such titles (pursuant to the applicable provisions of law, including sections 1866(a)(1) and 1832(a)(1)(F)(i)) only if, in accordance with this section, the hospital or center reports such information on health care-associated infections that develop in the hospital or center (and such de-

mographic information associated with such infections) as the Secretary specifies.

''(2) REPORTING PROTOCOLS.— Such information shall be reported in accordance with reporting protocols established by the Secretary through the Director of the Centers for Disease Control and Prevention (in this section referred to as the 'CDC') and to the National Healthcare Safety Network of the CDC or under such another reporting system of such Centers as determined appropriate by the Secretary in consultation with such Director.

''(3) COORDINATION WITH HIT.—The Secretary, through the Director of the CDC and the Office of the National Coordinator for Health Information Technology, shall ensure that the transmission of information under this subsection is coordinated with systems established under the HITECH Act, where appropriate.

''(4) PROCEDURES TO ENSURE THE VALIDITY OF INFORMATION.—The Secretary shall establish procedures regarding the validity of the information submitted under this subsection in order to ensure that such information is appropriately compared across hospitals and centers. Such procedures shall

address failures to report as well as errors in reporting.

''(5) IMPLEMENTATION.—Not later than 1 year after the date of enactment of this section, the Secretary, through the Director of CDC, shall promulgate regulations to carry out this section.

''(b) PUBLIC POSTING OF INFORMATION.—The Secretary shall promptly post, on the official public Internet site of the Department of Health and Human Services, the information reported under subsection (a). Such information shall be set forth in a manner that allows for the comparison of information on health care-associated infections—

''(1) among hospitals and ambulatory surgical centers; and

''(2) by demographic information.

''(c) ANNUAL REPORT TO CONGRESS.—On an annual basis the Secretary shall submit to the Congress a report that summarizes each of the following:

''(1) The number and types of health care-associated infections reported under subsection (a) in hospitals and ambulatory surgical centers during such year.

''(2) Factors that contribute to the occurrence of such infections, including health care worker immunization rates.

''(3) Based on the most recent information available to the Secretary on the composition of the professional staff of hospitals and ambulatory surgical centers, the number of certified infection control professionals on the staff of hospitals and ambulatory surgical centers.

''(4) The total increases or decreases in health care costs that resulted from increases or decreases in the rates of occurrence of each such type of infection during such year.

''(5) Recommendations, in coordination with the Center for Quality Improvement established under section 931 of the Public Health Service Act, for best practices to eliminate the rates of occurrence of each such type of infection in hospitals and ambulatory surgical centers.

''(d) NON-PREEMPTION OF STATE LAWS.—Nothing in this section shall be construed as preempting or otherwise affecting any provision of State law relating to the disclosure of information on health care-associated infections or patient safety procedures for a hospital or ambulatory surgical center.

''(e) HEALTH CARE-ASSOCIATED INFECTION.—For purposes of this section:

''(1) IN GENERAL.—The term 'health care-associated infection' means an infection that develops in a patient who has received care in any institutional setting where health care is delivered and is related to receiving health care.

''(2) RELATED TO RECEIVING HEALTH CARE.—The term 'related to receiving health care', with respect to an infection, means that the infection was not incubating or present at the time health care was provided.

''(f) APPLICATION TO CRITICAL ACCESS HOSPITALS.—For purposes of this section, the term 'hospital' includes a critical access hospital, as defined in section 1861(mm)(1).''.

(b) EFFECTIVE DATE.—With respect to section 1138A of the Social Security Act (as inserted by subsection (a) of this section), the requirement under such section that hospitals and ambulatory surgical centers submit reports takes effect on such date (not later than 2 years after the date of the enactment of this Act) as the Secretary of Health and Human Services shall specify. In order to meet such deadline, the Secretary may implement such section through guidance or other instructions.

(c) GAO REPORT.—Not later than 18 months after the date of the enactment of this Act, the Comptroller General of the United States shall submit to Congress a report on the program established under section 1138A of the Social Security Act, as inserted by subsection (a). Such report shall include an analysis of the appropriateness of the types of information required for submission, compliance with reporting requirements, the success of the validity procedures established, and any conflict or overlap between the reporting required under such section and any other reporting systems mandated by either the States or the Federal Government.

(d) REPORT ON ADDITIONAL DATA.—Not later than 18 months after the date of the enactment of this Act, the Secretary of Health and Human Services shall submit to the Congress a report on the appropriateness of expanding the requirements under such section to include additional information (such as health care worker immunization rates), in order to improve health care quality and patient safety.

TITLE V—MEDICARE GRADUATE MEDICAL EDUCATION

SEC. 1501. DISTRIBUTION OF UNUSED RESIDENCY POSITIONS.

(a) IN GENERAL.—Section 1886(h) of the Social Security Act (42 U.S.C. 1395ww(h)) is amended—

(1) in paragraph (4)(F)(i), by striking ''paragraph (7)'' and inserting ''paragraphs (7) and (8)'';

(2) in paragraph (4)(H)(i), by striking ''paragraph (7)'' and inserting ''paragraphs (7) and (8)'';

(3) in paragraph (7)(E), by inserting ''and paragraph (8)'' after ''this paragraph''; and

(4) by adding at the end the following new paragraph:

''(8) ADDITIONAL REDISTRIBUTION OF UNUSED RESIDENCY POSITIONS.—

''(A) REDUCTIONS IN LIMIT BASED ON UNUSED POSITIONS.—

''(i) PROGRAMS SUBJECT TO REDUCTION.—If a hospital's reference resident level (specified in clause (ii)) is less than the otherwise applicable resident limit (as defined in subparagraph (C)(ii)), effective for portions of cost reporting periods occurring on or after July 1, 2011, the oth-

erwise applicable resident limit shall be reduced by 90 percent of the difference between such otherwise applicable resident limit and such reference resident level.

''(ii) REFERENCE RESIDENT LEVEL.—

''(I) IN GENERAL.—Except as otherwise provided in a subsequent subclause, the reference resident level specified in this clause for a hospital is the highest resident level for any of the 3 most recent cost reporting periods (ending before the date of the enactment of this paragraph) of the hospital for which a cost report has been settled (or, if not, submitted (subject to audit)), as determined by the Secretary.

''(II) USE OF MOST RECENT ACCOUNTING PERIOD TO RECOGNIZE EXPANSION OF EXISTING PROGRAMS.—If a hospital submits a timely request to increase its resident level due to an expansion, or planned expansion, of an existing residency training program that is not reflected on the most

recent settled or submitted cost report, after audit and subject to the discretion of the Secretary, subject to subclause (IV), the reference resident level for such hospital is the resident level that includes the additional residents attributable to such expansion or establishment, as determined by the Secretary. The Secretary is authorized to determine an alternative reference resident level for a hospital that submitted to the Secretary a timely request, before the start of the 2009–2010 academic year, for an increase in its reference resident level due to a planned expansion.

''(III) SPECIAL PROVIDER AGREEMENT.—In the case of a hospital described in paragraph (4)(H)(v), the reference resident level specified in this clause is the limitation applicable under subclause (I) of such paragraph.

''(IV) PREVIOUS REDISTRIBUTION.—The reference resident level

specified in this clause for a hospital shall be increased to the extent required to take into account an increase in resident positions made available to the hospital under paragraph (7)(B) that are not otherwise taken into account under a previous subclause.

''(iii) AFFILIATION.—The provisions of clause (i) shall be applied to hospitals which are members of the same affiliated group (as defined by the Secretary under paragraph (4)(H)(ii)) and to the extent the hospitals can demonstrate that they are filling any additional resident slots allocated to other hospitals through an affiliation agreement, the Secretary shall adjust the determination of available slots accordingly, or which the Secretary otherwise has permitted the resident positions (under section 402 of the Social Security Amendments of 1967) to be aggregated for purposes of applying the resident position limitations under this subsection.

''(B) REDISTRIBUTION.—

''(i) IN GENERAL.—The Secretary shall increase the otherwise applicable resident limit for each qualifying hospital that submits an application under this subparagraph by such number as the Secretary may approve for portions of cost reporting periods occurring on or after July 1, 2011. The estimated aggregate number of increases in the otherwise applicable resident limit under this subparagraph may not exceed the Secretary's estimate of the aggregate reduction in such limits attributable to subparagraph (A).

''(ii) REQUIREMENTS FOR QUALIFYING HOSPITALS.—A hospital is not a qualifying hospital for purposes of this paragraph unless the following requirements are met:

''(I) MAINTENANCE OF PRIMARY CARE RESIDENT LEVEL.—The hospital maintains the number of primary care residents at a level that is not less than the base level of primary care residents increased by the number of additional primary care resi-

dent positions provided to the hospital under this subparagraph. For purposes of this subparagraph, the 'base level of primary care residents' for a hospital is the level of such residents as of a base period (specified by the Secretary), determined without regard to whether such positions were in excess of the otherwise applicable resident limit for such period but taking into account the application of subclauses (II) and (III) of subparagraph (A)(ii).

''(II) DEDICATED ASSIGNMENT OF ADDITIONAL RESIDENT POSITIONS TO PRIMARY CARE.—The hospital assigns all such additional resident positions for primary care residents.

''(III) ACCREDITATION.—The hospital's residency programs in primary care are fully accredited or, in the case of a residency training program not in operation as of the base year, the hospital is actively applying for such accreditation for the program

for such additional resident positions (as determined by the Secretary).

''(iii) CONSIDERATIONS IN REDISTRIBUTION.—In determining for which qualifying hospitals the increase in the otherwise applicable resident limit is provided under this subparagraph, the Secretary shall take into account the demonstrated likelihood of the hospital filling the positions within the first 3 cost reporting periods beginning on or after July 1, 2011, made available under this subparagraph, as determined by the Secretary.

''(iv) PRIORITY FOR CERTAIN HOSPITALS.—In determining for which qualifying hospitals the increase in the otherwise applicable resident limit is provided under this subparagraph, the Secretary shall distribute the increase to qualifying hospitals based on the following criteria:

''(I) The Secretary shall give preference to hospitals that had a reduction in resident training positions under subparagraph (A).

''(II) The Secretary shall give preference to hospitals with 3-year primary care residency training programs, such as family practice and general internal medicine.

''(III) The Secretary shall give preference to hospitals insofar as they have in effect formal arrangements (as determined by the Secretary) that place greater emphasis upon training in Federally qualified health centers, rural health clinics, and other nonprovider settings, and to hospitals that receive additional payments under subsection (d)(5)(F) and emphasize training in an outpatient department.

''(IV) The Secretary shall give preference to hospitals with a number of positions (as of July 1, 2009) in excess of the otherwise applicable resident limit for such period.

''(V) The Secretary shall give preference to hospitals that place greater emphasis upon training in a health professional shortage area (des-

ignated under section 332 of the Public Health Service Act) or a health professional needs area (designated under section 2211 of such Act).

''(VI) The Secretary shall give preference to hospitals in States that have low resident-to-population ratios (including a greater preference for those States with lower resident-to-population ratios).

''(v) LIMITATION.—In no case shall more than 20 full-time equivalent additional residency positions be made available under this subparagraph with respect to any hospital.

''(vi) APPLICATION OF PER RESIDENT AMOUNTS FOR PRIMARY CARE.—With respect to additional residency positions in a hospital attributable to the increase provided under this subparagraph, the approved FTE resident amounts are deemed to be equal to the hospital per resident amounts for primary care and nonprimary care computed under paragraph (2)(D) for that hospital.

''(vi) DISTRIBUTION.—The Secretary shall distribute the increase in resident training positions to qualifying hospitals under this subparagraph not later than July 1, 2011.

''(C) RESIDENT LEVEL AND LIMIT DEFINED.—In this paragraph:

''(i) The term 'resident level' has the meaning given such term in paragraph (7)(C)(i).

''(ii) The term 'otherwise applicable resident limit' means, with respect to a hospital, the limit otherwise applicable under subparagraphs (F)(i) and (H) of paragraph (4) on the resident level for the hospital determined without regard to this paragraph but taking into account paragraph (7)(A).

''(D) MAINTENANCE OF PRIMARY CARE RESIDENT LEVEL.—In carrying out this paragraph, the Secretary shall require hospitals that receive additional resident positions under subparagraph (B)—

''(i) to maintain records, and periodically report to the Secretary, on the num-

ber of primary care residents in its residency training programs; and

''(ii) as a condition of payment for a cost reporting period under this subsection for such positions, to maintain the level of such positions at not less than the sum of—

''(I) the base level of primary care resident positions (as determined under subparagraph (B)(ii)(I)) before receiving such additional positions; and

''(II) the number of such additional positions.''.

(b) IME.—

(1) IN GENERAL.—Section 1886(d)(5)(B)(v) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(B)(v)), in the second sentence, is amended—

(A) by striking ''subsection (h)(7)'' and inserting ''subsections (h)(7) and (h)(8)''; and

(B) by striking ''it applies'' and inserting ''they apply''.

(2) CONFORMING PROVISION.—Section 1886(d)(5)(B) of the Social Security Act (42 U.S.C.

1395ww(d)(5)(B)) is amended by adding at the end the following clause:

''(x) For discharges occurring on or after July 1, 2011, insofar as an additional payment amount under this subparagraph is attributable to resident positions distributed to a hospital under subsection (h)(8)(B), the indirect teaching adjustment factor shall be computed in the same manner as provided under clause (ii) with respect to such resident positions.''.

(c) CONFORMING AMENDMENT.—Section 422(b)(2) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173) is amended by striking ''section 1886(h)(7)'' and all that follows and inserting ''paragraphs (7) and (8) of subsection (h) of section 1886 of the Social Security Act''.

SEC. 1502. INCREASING TRAINING IN NONPROVIDER SETTINGS.

(a) DIRECT GME.—Section 1886(h)(4)(E) of the Social Security Act (42 U.S.C. 1395ww(h)) is amended—

(1) by designating the first sentence as a clause (i) with the heading ''IN GENERAL'' and appropriate indentation;

(2) by striking ''shall be counted and that all the time'' and inserting ''shall be counted and that—

''(I) effective for cost reporting periods beginning before July 1, 2009, all the time'';

(3) in subclause (I), as inserted by paragraph (1), by striking the period at the end and inserting ''; and''; and

(A) by inserting after subclause (I), as so inserted, the following:

''(II) effective for cost reporting periods beginning on or after July 1, 2009, all the time so spent by a resident shall be counted towards the determination of full-time equivalency, without regard to the setting in which the activities are performed, if the hospital incurs the costs of the stipends and fringe benefits of the resident during the time the resident spends in that setting.

Any hospital claiming under this subparagraph for time spent in a nonprovider setting shall maintain and make available to the Secretary records regarding the amount of such time and such amount in comparison with amounts of such time in

such base year as the Secretary shall specify.''.

(b) IME.—Section 1886(d)(5)(B)(iv) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(B)(iv)) is amended—

(1) by striking ''(iv) Effective for discharges occurring on or after October 1, 1997'' and inserting ''(iv)(I) Effective for discharges occurring on or after October 1, 1997, and before July 1, 2009''; and

(2) by inserting after subclause (I), as inserted by paragraph (1), the following new subclause:

''(II) Effective for discharges occurring on or after July 1, 2009, all the time spent by an intern or resident in patient care activities at an entity in a nonprovider setting shall be counted towards the determination of full-time equivalency if the hospital incurs the costs of the stipends and fringe benefits of the intern or resident during the time the intern or resident spends in that setting.''.

(c) OIG STUDY ON IMPACT ON TRAINING.—The Inspector General of the Department of Health and Human Services shall analyze the data collected by the Secretary of Health and Human Services from the records made available to the Secretary under section 1886(h)(4)(E) of

the Social Security Act, as amended by subsection (a), in order to assess the extent to which there is an increase in time spent by medical residents in training in nonprovider settings as a result of the amendments made by this section. Not later than 4 years after the date of the enactment of this Act, the Inspector General shall submit a report to Congress on such analysis and assessment.

(d) DEMONSTRATION PROJECT FOR APPROVED TEACHING HEALTH CENTERS.—

(1) IN GENERAL.—The Secretary of Health and Human Services shall conduct a demonstration project under which an approved teaching health center (as defined in paragraph (3)) would be eligible for payment under subsections (h) and (k) of section 1886 of the Social Security Act (42 U.S.C. 1395ww) of amounts for its own direct costs of graduate medical education activities for primary care residents, as well as for the direct costs of graduate medical education activities of its contracting hospital for such residents, in a manner similar to the manner in which such payments would be made to a hospital if the hospital were to operate such a program.

(2) CONDITIONS.—Under the demonstration project—

(A) an approved teaching health center shall contract with an accredited teaching hospital to carry out the inpatient responsibilities of the primary care residency program of the hospital involved and is responsible for payment to the hospital for the hospital's costs of the salary and fringe benefits for residents in the program;

(B) the number of primary care residents of the center shall not count against the contracting hospital's resident limit; and

(C) the contracting hospital shall agree not to diminish the number of residents in its primary care residency training program.

(3) APPROVED TEACHING HEALTH CENTER DEFINED.—In this subsection, the term ''approved teaching health center'' means a nonprovider setting, such as a Federally qualified health center or rural health clinic (as defined in section 1861(aa) of the Social Security Act), that develops and operates an accredited primary care residency program for which funding would be available if it were operated by a hospital.

SEC. 1503. RULES FOR COUNTING RESIDENT TIME FOR DIDACTIC AND SCHOLARLY ACTIVITIES AND OTHER ACTIVITIES.

(a) DIRECT GME.—Section 1886(h) of the Social Security Act (42 U.S.C. 1395ww(h)) is amended—

(1) in paragraph (4)(E), as amended by section 1502(a)—

(A) in clause (i), by striking ''Such rules'' and inserting ''Subject to clause (ii), such rules''; and

(B) by adding at the end the following new clause:

''(ii) TREATMENT OF CERTAIN NONPROVIDER AND DIDACTIC ACTIVITIES.—Such rules shall provide that all time spent by an intern or resident in an approved medical residency training program in a nonprovider setting that is primarily engaged in furnishing patient care (as defined in paragraph (5)(K)) in nonpatient care activities, such as didactic conferences and seminars, but not including research not associated with the treatment or diagnosis of a particular patient, as such time and activities are defined by the Secretary,

shall be counted toward the determination of full-time equivalency.'';

(2) in paragraph (4), by adding at the end the following new subparagraph:

''(I) In determining the hospital's number of full-time equivalent residents for purposes of this subsection, all the time that is spent by an intern or resident in an approved medical residency training program on vacation, sick leave, or other approved leave, as such time is defined by the Secretary, and that does not prolong the total time the resident is participating in the approved program beyond the normal duration of the program shall be counted toward the determination of full-time equivalency.''; and

(3) in paragraph (5), by adding at the end the following new subparagraph:

''(K) NONPROVIDER SETTING THAT IS PRIMARILY ENGAGED IN FURNISHING PATIENT CARE.—The term 'nonprovider setting that is primarily engaged in furnishing patient care' means a nonprovider setting in which the primary activity is the care and treatment of patients, as defined by the Secretary.''.

(b) IME DETERMINATIONS.—Section 1886(d)(5)(B) of such Act (42 U.S.C. 1395ww(d)(5)(B)), as amended by section 1501(b), is amended by adding at the end the following new clause:

''(xi)(I) The provisions of subparagraph (I) of subsection (h)(4) shall apply under this subparagraph in the same manner as they apply under such subsection.

''(II) In determining the hospital's number of full-time equivalent residents for purposes of this subparagraph, all the time spent by an intern or resident in an approved medical residency training program in non-patient care activities, such as didactic conferences and seminars, as such time and activities are defined by the Secretary, that occurs in the hospital shall be counted toward the determination of full-time equivalency if the hospital—

''(aa) is recognized as a subsection (d) hospital;

''(bb) is recognized as a subsection (d) Puerto Rico hospital;

''(cc) is reimbursed under a reimbursement system authorized under section 1814(b)(3); or

''(dd) is a provider-based hospital outpatient department.

''(III) In determining the hospital's number of full-time equivalent residents for purposes of this subpara-

graph, all the time spent by an intern or resident in an approved medical residency training program in research activities that are not associated with the treatment or diagnosis of a particular patient, as such time and activities are defined by the Secretary, shall not be counted toward the determination of full-time equivalency.''.

(c) EFFECTIVE DATES; APPLICATION.—

(1) IN GENERAL.—Except as otherwise provided, the Secretary of Health and Human Services shall implement the amendments made by this section in a manner so as to apply to cost reporting periods beginning on or after January 1, 1983.

(2) DIRECT GME.—Section 1886(h)(4)(E)(ii) of the Social Security Act, as added by subsection (a)(1)(B), shall apply to cost reporting periods beginning on or after July 1, 2008.

(3) IME.—Section 1886(d)(5)(B)(x)(III) of the Social Security Act, as added by subsection (b), shall apply to cost reporting periods beginning on or after October 1, 2001. Such section, as so added, shall not give rise to any inference on how the law in effect prior to such date should be interpreted.

(4) APPLICATION.—The amendments made by this section shall not be applied in a manner that requires reopening of any settled hospital cost reports

as to which there is not a jurisdictionally proper appeal pending as of the date of the enactment of this Act on the issue of payment for indirect costs of medical education under section 1886(d)(5)(B) of the Social Security Act or for direct graduate medical education costs under section 1886(h) of such Act.

SEC. 1504. PRESERVATION OF RESIDENT CAP POSITIONS FROM CLOSED HOSPITALS.

(a) DIRECT GME.—Section 1886(h)(4)(H) of the Social Security Act (42 U.S.C. Section 1395ww(h)(4)(H)) is amended by adding at the end the following new clause:

''(vi) REDISTRIBUTION OF RESIDENCY SLOTS AFTER A HOSPITAL CLOSES.—

''(I) IN GENERAL.—The Secretary shall, by regulation, establish a process consistent with subclauses (II) and (III) under which, in the case where a hospital (other than a hospital described in clause (v)) with an approved medical residency program in a State closes on or after the date that is 2 years before the date of the enactment of this clause, the Secretary shall increase the otherwise ap-

plicable resident limit under this paragraph for other hospitals in the State in accordance with this clause.

''(II) PROCESS FOR HOSPITALS IN CERTAIN AREAS.—In determining for which hospitals the increase in the otherwise applicable resident limit described in subclause (I) is provided, the Secretary shall establish a process to provide for such increase to one or more hospitals located in the State. Such process shall take into consideration the recommendations submitted to the Secretary by the senior health official (as designated by the chief executive officer of such State) if such recommendations are submitted not later than 180 days after the date of the hospital closure involved (or, in the case of a hospital that closed after the date that is 2 years before the date of the enactment of this clause, 180 days after such date of enactment).

''(III) LIMITATION.—The estimated aggregate number of increases in the otherwise applicable resident limits for hospitals under this clause shall be equal to the estimated number of resident positions in the approved medical residency programs that closed on or after the date described in subclause (I).''.

(b) NO EFFECT ON TEMPORARY FTE CAP ADJUSTMENTS.—The amendments made by this section shall not effect any temporary adjustment to a hospital's FTE cap under section 413.79(h) of title 42, Code of Federal Regulations (as in effect on the date of enactment of this Act) and shall not affect the application of section 1886(h)(4)(H)(v) of the Social Security Act.

(c) CONFORMING AMENDMENTS.—

(1) Section 422(b)(2) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173), as amended by section 1501(c), is amended by striking ''(7) and'' and inserting ''(4)(H)(vi), (7), and''.

(2) Section 1886(h)(7)(E) of the Social Security Act (42 U.S.C. 1395ww(h)(7)(E)) is amended

by inserting ''or under paragraph (4)(H)(vi)'' after ''under this paragraph''.

SEC. 1505. IMPROVING ACCOUNTABILITY FOR APPROVED MEDICAL RESIDENCY TRAINING.

(a) SPECIFICATION OF GOALS FOR APPROVED MEDICAL RESIDENCY TRAINING PROGRAMS.—Section 1886(h)(1) of the Social Security Act (42 U.S.C. 1395ww(h)(1)) is amended—

(1) by designating the matter beginning with ''Notwithstanding'' as a subparagraph (A) with the heading ''IN GENERAL.—'' and with appropriate indentation; and

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

''(B) GOALS AND ACCOUNTABILITY FOR APPROVED MEDICAL RESIDENCY TRAINING PROGRAMS.—The goals of medical residency training programs are to foster a physician workforce so that physicians are trained to be able to do the following:

''(i) Work effectively in various health care delivery settings, such as nonprovider settings.

''(ii) Coordinate patient care within and across settings relevant to their specialties.

''(iii) Understand the relevant cost and value of various diagnostic and treatment options.

''(iv) Work in inter-professional teams and multi-disciplinary team-based models in provider and nonprovider settings to enhance safety and improve quality of patient care.

''(v) Be knowledgeable in methods of identifying systematic errors in health care delivery and in implementing systematic solutions in case of such errors, including experience and participation in continuous quality improvement projects to improve health outcomes of the population the physicians serve.

''(vi) Be meaningful EHR users (as determined under section 1848(o)(2)) in the delivery of care and in improving the quality of the health of the community and the individuals that the hospital serves.''

(b) GAO STUDY ON EVALUATION OF TRAINING PROGRAMS.—

(1) IN GENERAL.—The Comptroller General of the United States shall conduct a study to evaluate the extent to which medical residency training programs—

(A) are meeting the goals described in section 1886(h)(1)(B) of the Social Security Act, as added by subsection (a), in a range of residency programs, including primary care and other specialties; and

(B) have the appropriate faculty expertise to teach the topics required to achieve such goals.

(2) REPORT.—Not later than 18 months after the date of the enactment of this Act, the Comptroller General shall submit to Congress a report on such study and shall include in such report recommendations as to how medical residency training programs could be further encouraged to meet such goals through means such as—

(A) development of curriculum requirements; and

(B) assessment of the accreditation processes of the Accreditation Council for Graduate

Medical Education and the American Osteopathic Association and effectiveness of those processes in accrediting medical residency programs that meet the goals referred to in paragraph (1)(A).

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.

(a) IN GENERAL.—Section 1817(k) of the Social Security Act (42 U.S.C. 1395i(k)) is amended—

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

''(7) ADDITIONAL FUNDING.—In addition to the funds otherwise appropriated to the Account from the Trust Fund under paragraphs (3) and (4) and for purposes described in paragraphs (3)(C) and (4)(A), there are hereby appropriated an additional $100,000,000 to such Account from such Trust Fund for each fiscal year beginning with 2011. The funds appropriated under this paragraph shall be allocated in the same proportion as the total funding appropriated with respect to paragraphs (3)(A) and (4)(A) was allocated with respect to fiscal year

2010, and shall be available without further appropriation until expended.''.

(2) in paragraph (4)(A)—

(A) by inserting ''for activities described in paragraph (3)(C) and'' after ''necessary''; and

(B) by inserting ''until expended'' after ''appropriation''.

(b) FLEXIBILITY IN PURSUING FRAUD AND ABUSE.—Section 1893(a) of the Social Security Act (42 U.S.C. 1395ddd(a)) is amended by inserting '', or otherwise,'' after ''entities''.

Subtitle B—Enhanced Penalties for Fraud and Abuse

SEC. 1611. ENHANCED PENALTIES FOR FALSE STATEMENTS ON PROVIDER OR SUPPLIER ENROLLMENT APPLICATIONS.

(a) IN GENERAL.—Section 1128A(a) of the Social Security Act (42 U.S.C. 1320a–7a(a)) is amended—

(1) in paragraph (1)(D), by striking all that follows ''in which the person was excluded'' and inserting ''under Federal law from the Federal health care program under which the claim was made, or'';

(2) by striking ''or'' at the end of paragraph (6);

(3) in paragraph (7), by inserting at the end ''or'';

(4) by inserting after paragraph (7) the following new paragraph:

''(8) knowingly makes or causes to be made any false statement, omission, or misrepresentation of a material fact in any application, agreement, bid, or contract to participate or enroll as a provider of services or supplier under a Federal health care program, including managed care organizations under title XIX, Medicare Advantage organizations under part C of title XVIII, prescription drug plan sponsors under part D of title XVIII, and entities that apply to participate as providers of services or suppliers in such managed care organizations and such plans;'';

(5) in the matter following paragraph (8), as inserted by paragraph (4), by striking ''or in cases under paragraph (7), $ 50,000 for each such act)'' and inserting ''in cases under paragraph (7), $50,000 for each such act, or in cases under paragraph (8), $50,000 for each false statement, omission, or misrepresentation of a material fact)''; and

(6) in the second sentence, by striking ''for a lawful purpose)'' and inserting ''for a lawful pur-

pose, or in cases under paragraph (8), an assessment of not more than 3 times the amount claimed as the result of the false statement, omission, or misrepresentation of material fact claimed by a provider of services or supplier whose application to participate contained such false statement, omission, or misrepresentation)''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to acts committed on or after January 1, 2010.

SEC. 1612. ENHANCED PENALTIES FOR SUBMISSION OF FALSE STATEMENTS MATERIAL TO A FALSE CLAIM.

(a) IN GENERAL.—Section 1128A(a) of the Social Security Act (42 U.S.C. 1320a–7a(a)), as amended by section 1611, is further amended—

(1) in paragraph (7), by striking ''or'' at the end;

(2) in paragraph (8), by inserting ''or'' at the end; and

(3) by inserting after paragraph (8), the following new paragraph:

''(9) knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim for payment for items

and services furnished under a Federal health care program;''; and

(4) in the matter following paragraph (9), as inserted by paragraph (3)—

(A) by striking ''or in cases under paragraph (8)'' and inserting ''in cases under paragraph (8)''; and

(B) by striking ''a material fact)'' and inserting ''a material fact, in cases under paragraph (9), $50,000 for each false record or statement)''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to acts committed on or after January 1, 2010.

SEC. 1613. ENHANCED PENALTIES FOR DELAYING INSPECTIONS.

(a) IN GENERAL.—Section 1128A(a) of the Social Security Act (42 U.S.C. 1320a–7a(a)), as amended by sections 1611 and 1612, is further amended—

(1) in paragraph (8), by striking ''or'' at the end;

(2) in paragraph (9), by inserting ''or'' at the end;

(3) by inserting after paragraph (9) the following new paragraph:

''(10) fails to grant timely access, upon reasonable request (as defined by the Secretary in regulations), to the Inspector General of the Department of Health and Human Services, for the purpose of audits, investigations, evaluations, or other statutory functions of the Inspector General of the Department of Health and Human Services;''; and

(4) in the matter following paragraph (10), as inserted by paragraph (3)—

(A) by striking ''or'' after ''$50,000 for each such act,''; and

(B) by inserting '', or in cases under paragraph (10), $15,000 for each day of the failure described in such paragraph'' after ''false record or statement''.

(b) ENSURING TIMELY INSPECTIONS RELATING TO CONTRACTS WITH MA ORGANIZATIONS.—Section 1857(d)(2) of such Act (42 U.S.C. 1395w–27(d)(2)) is amended—

(1) in subparagraph (A), by inserting ''timely'' before ''inspect''; and

(2) in subparagraph (B), by inserting ''timely'' before ''audit and inspect''.

(c) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to violations committed on or after January 1, 2010.

SEC. 1614. ENHANCED HOSPICE PROGRAM SAFEGUARDS.

(a) MEDICARE.—Part A of title XVIII of the Social Security Act is amended by inserting after section 1819 the following new section:

"**SEC. 1819A. ASSURING QUALITY OF CARE IN HOSPICE CARE.**

''(a) IN GENERAL.—If the Secretary determines on the basis of a survey or otherwise, that a hospice program that is certified for participation under this title has demonstrated a substandard quality of care and failed to meet such other requirements as the Secretary may find necessary in the interest of the health and safety of the individuals who are provided care and services by the agency or organization involved and determines—

''(1) that the deficiencies involved immediately jeopardize the health and safety of the individuals to whom the program furnishes items and services, the Secretary shall take immediate action to remove the jeopardy and correct the deficiencies through the remedy specified in subsection (b)(2)(A)(iii) or terminate the certification of the program, and may

provide, in addition, for 1 or more of the other remedies described in subsection (b)(2)(A); or

''(2) that the deficiencies involved do not immediately jeopardize the health and safety of the individuals to whom the program furnishes items and services, the Secretary may—

''(A) impose intermediate sanctions developed pursuant to subsection (b), in lieu of terminating the certification of the program; and

''(B) if, after such a period of intermediate sanctions, the program is still not in compliance with such requirements, the Secretary shall terminate the certification of the program.

If the Secretary determines that a hospice program that is certified for participation under this title is in compliance with such requirements but, as of a previous period, was not in compliance with such requirements, the Secretary may provide for a civil money penalty under subsection (b)(2)(A)(i) for the days in which it finds that the program was not in compliance with such requirements.

''(b) INTERMEDIATE SANCTIONS.—

''(1) DEVELOPMENT AND IMPLEMENTATION.—The Secretary shall develop and implement, by not later than July 1, 2012—

''(A) a range of intermediate sanctions to apply to hospice programs under the conditions described in subsection (a), and

''(B) appropriate procedures for appealing determinations relating to the imposition of such sanctions.

''(2) SPECIFIED SANCTIONS.—

''(A) IN GENERAL.—The intermediate sanctions developed under paragraph (1) may include—

''(i) civil money penalties in an amount not to exceed $10,000 for each day of noncompliance or, in the case of a per instance penalty applied by the Secretary, not to exceed $25,000,

''(ii) denial of all or part of the payments to which a hospice program would otherwise be entitled under this title with respect to items and services furnished by a hospice program on or after the date on which the Secretary determines that intermediate sanctions should be imposed pursuant to subsection (a)(2),

''(iii) the appointment of temporary management to oversee the operation of

the hospice program and to protect and assure the health and safety of the individuals under the care of the program while improvements are made,

''(iv) corrective action plans, and

''(v) in-service training for staff.

The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under clause (i) in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a). The temporary management under clause (iii) shall not be terminated until the Secretary has determined that the program has the management capability to ensure continued compliance with all requirements referred to in that clause.

''(B) CLARIFICATION.—The sanctions specified in subparagraph (A) are in addition to sanctions otherwise available under State or Federal law and shall not be construed as limiting other remedies, including any remedy available to an individual at common law.

''(C) COMMENCEMENT OF PAYMENT.—A denial of payment under subparagraph (A)(ii) shall terminate when the Secretary determines

that the hospice program no longer demonstrates a substandard quality of care and meets such other requirements as the Secretary may find necessary in the interest of the health and safety of the individuals who are provided care and services by the agency or organization involved.

''(3) SECRETARIAL AUTHORITY.—The Secretary shall develop and implement, by not later than July 1, 2011, specific procedures with respect to the conditions under which each of the intermediate sanctions developed under paragraph (1) is to be applied, including the amount of any fines and the severity of each of these sanctions. Such procedures shall be designed so as to minimize the time between identification of deficiencies and imposition of these sanctions and shall provide for the imposition of incrementally more severe fines for repeated or uncorrected deficiencies.''.

(b) APPLICATION TO MEDICAID.—Section 1905(o) of the Social Security Act (42 U.S.C. 1396d(o)) is amended by adding at the end the following new paragraph:

''(4) The provisions of section 1819A shall apply to a hospice program providing hospice care under this title

in the same manner as such provisions apply to a hospice program providing hospice care under title XVIII.''.

(c) APPLICATION TO CHIP.—Title XXI of the Social Security Act is amended by adding at the end the following new section:

''**SEC. 2114. ASSURING QUALITY OF CARE IN HOSPICE CARE.**

''The provisions of section 1819A shall apply to a hospice program providing hospice care under this title in the same manner such provisions apply to a hospice program providing hospice care under title XVIII.''.

SEC. 1615. ENHANCED PENALTIES FOR INDIVIDUALS EXCLUDED FROM PROGRAM PARTICIPATION.

(a) IN GENERAL.—Section 1128A(a) of the Social Security Act (42 U.S.C. 1320a–7a(a)), as amended by the previous sections, is further amended—

(1) by striking ''or'' at the end of paragraph (9);

(2) by inserting ''or'' at the end of paragraph (10);

(3) by inserting after paragraph (10) the following new paragraph:

''(11) orders or prescribes an item or service, including without limitation home health care, diagnostic and clinical lab tests, prescription drugs, durable medical equipment, ambulance services, phys-

ical or occupational therapy, or any other item or service, during a period when the person has been excluded from participation in a Federal health care program, and the person knows or should know that a claim for such item or service will be presented to such a program;''; and

(4) in the matter following paragraph (11), as inserted by paragraph (2), by striking ''$15,000 for each day of the failure described in such paragraph'' and inserting ''$15,000 for each day of the failure described in such paragraph, or in cases under paragraph (11), $50,000 for each order or prescription for an item or service by an excluded individual''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to violations committed on or after January 1, 2010.

SEC. 1616. ENHANCED PENALTIES FOR PROVISION OF FALSE INFORMATION BY MEDICARE ADVANTAGE AND PART D PLANS.

(a) IN GENERAL.—Section 1857(g)(2)(A) of the Social Security Act (42 U.S.C. 1395w—27(g)(2)(A)) is amended by inserting ''except with respect to a determination under subparagraph (E), an assessment of not more than 3 times the amount claimed by such plan or plan

sponsor based upon the misrepresentation or falsified information involved,'' after ''for each such determination,''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to violations committed on or after January 1, 2010.

SEC. 1617. ENHANCED PENALTIES FOR MEDICARE ADVANTAGE AND PART D MARKETING VIOLATIONS.

(a) IN GENERAL.—Section 1857(g)(1) of the Social Security Act (42 U.S.C. 1395w—27(g)(1)), as amended by section 1221(b), is amended—

(1) in subparagraph (G), by striking ''or'' at the end;

(2) by inserting after subparagraph (H) the following new subparagraphs:

''(I) except as provided under subparagraph (C) or (D) of section 1860D–1(b)(1), enrolls an individual in any plan under this part without the prior consent of the individual or the designee of the individual;

''(J) transfers an individual enrolled under this part from one plan to another without the prior consent of the individual or the designee of the individual or solely for the purpose of earning a commission;

''(K) fails to comply with marketing restrictions described in subsections (h) and (j) of section 1851 or applicable implementing regulations or guidance; or

''(L) employs or contracts with any individual or entity who engages in the conduct described in subparagraphs (A) through (K) of this paragraph;''; and

(3) by adding at the end the following new sentence: ''The Secretary may provide, in addition to any other remedies authorized by law, for any of the remedies described in paragraph (2), if the Secretary determines that any employee or agent of such organization, or any provider or supplier who contracts with such organization, has engaged in any conduct described in subparagraphs (A) through (L) of this paragraph.''

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to violations committed on or after January 1, 2010.

SEC. 1618. ENHANCED PENALTIES FOR OBSTRUCTION OF PROGRAM AUDITS.

(a) IN GENERAL.—Section 1128(b)(2) of the Social Security Act (42 U.S.C. 1320a–7(b)(2)) is amended—

(1) in the heading, by inserting ''OR AUDIT'' after ''INVESTIGATION''; and

(2) by striking ''investigation into'' and all that follows through the period and inserting ''investigation or audit related to—''

''(i) any offense described in paragraph (1) or in subsection (a); or

''(ii) the use of funds received, directly or indirectly, from any Federal health care program (as defined in section 1128B(f)).''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to violations committed on or after January 1, 2010.

SEC. 1619. EXCLUSION OF CERTAIN INDIVIDUALS AND ENTITIES FROM PARTICIPATION IN MEDICARE AND STATE HEALTH CARE PROGRAMS.

(a) IN GENERAL.—Section 1128(c) of the Social Security Act, as previously amended by this division, is further amended—

(1) in the heading, by striking ''AND PERIOD'' and inserting '', PERIOD, AND EFFECT''; and

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

''(4)(A) For purposes of this Act, subject to subparagraph (C), the effect of exclusion is that no payment may be made by any Federal health care program (as defined in section 1128B(f)) with respect to any item or service furnished—

''(i) by an excluded individual or entity; or

''(ii) at the medical direction or on the prescription of a physician or other authorized individual when the person submitting a claim for such item or service knew or had reason to know of the exclusion of such individual.

''(B) For purposes of this section and sections 1128A and 1128B, subject to subparagraph (C), an item or service has been furnished by an individual or entity if the individual or entity directly or indirectly provided, ordered, manufactured, distributed, prescribed, or otherwise supplied the item or service regardless of how the item or service was paid for by a Federal health care program or to whom such payment was made.

''(C)(i) Payment may be made under a Federal health care program for emergency items or services (not including items or services furnished in an emergency room of a hospital) furnished by an excluded individual or entity, or at the medical direc-

tion or on the prescription of an excluded physician or other authorized individual during the period of such individual's exclusion.

''(ii) In the case that an individual eligible for benefits under title XVIII or XIX submits a claim for payment for items or services furnished by an excluded individual or entity, and such individual eligible for such benefits did not know or have reason to know that such excluded individual or entity was so excluded, then, notwithstanding such exclusion, payment shall be made for such items or services. In such case the Secretary shall notify such individual eligible for such benefits of the exclusion of the individual or entity furnishing the items or services. Payment shall not be made for items or services furnished by an excluded individual or entity to an individual eligible for such benefits after a reasonable time (as determined by the Secretary in regulations) after the Secretary has notified the individual eligible for such benefits of the exclusion of the individual or entity furnishing the items or services.

''(iii) In the case that a claim for payment for items or services furnished by an excluded individual or entity is submitted by an individual or entity other than an individual eligible for benefits under

title XVIII or XIX or the excluded individual or entity, and the Secretary determines that the individual or entity that submitted the claim took reasonable steps to learn of the exclusion and reasonably relied upon inaccurate or misleading information from the relevant Federal health care program or its contractor, the Secretary may waive repayment of the amount paid in violation of the exclusion to the individual or entity that submitted the claim for the items or services furnished by the excluded individual or entity. If a Federal health care program contractor provided inaccurate or misleading information that resulted in the waiver of an overpayment under this clause, the Secretary shall take appropriate action to recover the improperly paid amount from the contractor.''.

Subtitle C—Enhanced Program and Provider Protections

SEC. 1631. ENHANCED CMS PROGRAM PROTECTION AUTHORITY.

(a) IN GENERAL.—Title XI of the Social Security Act (42 U.S.C. 1301 et seq.) is amended by inserting after section 1128F the following new section:

"**SEC. 1128G. ENHANCED PROGRAM AND PROVIDER PROTECTIONS IN THE MEDICARE, MEDICAID, AND CHIP PROGRAMS.**

"(a) CERTAIN AUTHORIZED SCREENING, ENHANCED OVERSIGHT PERIODS, AND ENROLLMENT MORATORIA.—

"(1) IN GENERAL.—For periods beginning after January 1, 2011, in the case that the Secretary determines there is a significant risk of fraudulent activity (as determined by the Secretary based on relevant complaints, reports, referrals by law enforcement or other sources, data analysis, trending information, or claims submissions by providers of services and suppliers) with respect to a category of provider of services or supplier of items or services, including a category within a geographic area, under title XVIII, XIX, or XXI, the Secretary may impose any of the following requirements with respect to a provider of services or a supplier (whether such provider or supplier is initially enrolling in the program or is renewing such enrollment):

"(A) Screening under paragraph (2).

"(B) Enhanced oversight periods under paragraph (3).

"(C) Enrollment moratoria under paragraph (4).

In applying this subsection for purposes of title XIX and XXI the Secretary may require a State to carry out the provisions of this subsection as a requirement of the State plan under title XIX or the child health plan under title XXI. Actions taken and determinations made under this subsection shall not be subject to review by a judicial tribunal.

''(2) SCREENING.—For purposes of paragraph (1), the Secretary shall establish procedures under which screening is conducted with respect to providers of services and suppliers described in such paragraph. Such screening may include—

''(A) licensing board checks;

''(B) screening against the list of individuals and entities excluded from the program under title XVIII, XIX, or XXI;

''(C) the excluded provider list system;

''(D) background checks; and

''(E) unannounced pre-enrollment or other site visits.

''(3) ENHANCED OVERSIGHT PERIOD.—For purposes of paragraph (1), the Secretary shall establish procedures to provide for a period of not less than 30 days and not more than 365 days during which providers of services and suppliers described

in such paragraph, as the Secretary determines appropriate, would be subject to enhanced oversight, such as required or unannounced (or required and unannounced) site visits or inspections, prepayment review, enhanced review of claims, and such other actions as specified by the Secretary, under the programs under titles XVIII, XIX, and XXI. Under such procedures, the Secretary may extend such period for more than 365 days if the Secretary determines that after the initial period such additional period of oversight is necessary.

''(4) MORATORIUM ON ENROLLMENT OF PROVIDERS AND SUPPLIERS.—For purposes of paragraph (1), the Secretary, based upon a finding of a risk of serious ongoing fraud within a program under title XVIII, XIX, or XXI, may impose a moratorium on the enrollment of providers of services and suppliers within a category of providers of services and suppliers (including a category within a specific geographic area) under such title. Such a moratorium may only be imposed if the Secretary makes a determination that the moratorium would not adversely impact access of individuals to care under such program.

''(5) CLARIFICATION.—Nothing in this subsection shall be interpreted to preclude or limit the ability of a State to engage in provider screening or enhanced provider oversight activities beyond those required by the Secretary.''.

(b) CONFORMING AMENDMENTS.—

(1) MEDICAID.—Section 1902(a) of the Social Security Act (42 U.S.C. 42 U.S.C. 1396a(a)) is amended—

(A) in paragraph (23), by inserting before the semicolon at the end the following: ''or by a person to whom or entity to which a moratorium under section 1128G(a)(4) is applied during the period of such moratorium'';

(B) in paragraph (72); by striking at the end ''and'';

(C) in paragraph (73), by striking the period at the end and inserting ''and''; and

(D) by adding after paragraph (73) the following new paragraph:

''(74) provide that the State will enforce any determination made by the Secretary under subsection (a) of section 1128G (relating to a significant risk of fraudulent activity with respect to a category of provider or supplier described in such sub-

section (a) through use of the appropriate procedures described in such subsection (a)), and that the State will carry out any activities as required by the Secretary for purposes of such subsection (a).''.

(2) CHIP.—Section 2102 of such Act (42 U.S.C. 1397bb) is amended by adding at the end the following new subsection:

''(d) PROGRAM INTEGRITY.—A State child health plan shall include a description of the procedures to be used by the State—

''(1) to enforce any determination made by the Secretary under subsection (a) of section 1128G (relating to a significant risk of fraudulent activity with respect to a category of provider or supplier described in such subsection through use of the appropriate procedures described in such subsection); and

''(2) to carry out any activities as required by the Secretary for purposes of such subsection.''.

(3) MEDICARE.—Section 1866(j) of such Act (42 U.S.C. 1395cc(j)) is amended by adding at the end the following new paragraph:

''(3) PROGRAM INTEGRITY.—The provisions of section 1128G(a) apply to enrollments and renewals of enrollments of providers of services and suppliers under this title.''.

SEC. 1632. ENHANCED MEDICARE, MEDICAID, AND CHIP PROGRAM DISCLOSURE REQUIREMENTS RELATING TO PREVIOUS AFFILIATIONS.

(a) IN GENERAL.—Section 1128G of the Social Security Act, as inserted by section 1631, is amended by adding at the end the following new subsection:

''(b) ENHANCED PROGRAM DISCLOSURE REQUIREMENTS.—

''(1) DISCLOSURE.—A provider of services or supplier who submits on or after July 1, 2011, an application for enrollment and renewing enrollment in a program under title XVIII, XIX, or XXI shall disclose (in a form and manner determined by the Secretary) any current affiliation or affiliation within the previous 10-year period with a provider of services or supplier that has uncollected debt or with a person or entity that has been suspended or excluded under such program, subject to a payment suspension, or has had its billing privileges revoked.

''(2) ENHANCED SAFEGUARDS.—If the Secretary determines that such previous affiliation of such provider or supplier poses a risk of fraud, waste, or abuse, the Secretary may apply such enhanced safeguards as the Secretary determines necessary to reduce such risk associated with such provider or supplier enrolling or participating in the

program under title XVIII, XIX, or XXI. Such safeguards may include enhanced oversight, such as enhanced screening of claims, required or unannounced (or required and unannounced) site visits or inspections, additional information reporting requirements, and conditioning such enrollment on the provision of a surety bond.

''(3) AUTHORITY TO DENY PARTICIPATION.—If the Secretary determines that there has been at least one such affiliation and that such affiliation or affiliations, as applicable, of such provider or supplier poses a serious risk of fraud, waste, or abuse, the Secretary may deny the application of such provider or supplier.''.

(b) CONFORMING AMENDMENTS.—

(1) MEDICAID.—Paragraph (74) of section 1902(a) of such Act (42 U.S.C. 1396a(a)), as added by section 1631(b)(1), is amended—

(A) by inserting ''or subsection (b) of such section (relating to disclosure requirements)'' before '', and that the State''; and

(B) by inserting before the period the following: ''and apply any enhanced safeguards, with respect to a provider or supplier described

in such subsection (b), as the Secretary determines necessary under such subsection (b)''.

(2) CHIP.—Subsection (d) of section 2102 of such Act (42 U.S.C. 1397bb), as added by section 1631(b)(2), is amended—

(A) in paragraph (1), by striking at the end ''and'';

(B) in paragraph (2) by striking the period at the end and inserting ''; and' '' and

(C) by adding at the end the following new paragraph:

''(3) to enforce any determination made by the Secretary under subsection (b) of section 1128G (relating to disclosure requirements) and to apply any enhanced safeguards, with respect to a provider or supplier described in such subsection, as the Secretary determines necessary under such subsection.''.

SEC. 1633. REQUIRED INCLUSION OF PAYMENT MODIFIER FOR CERTAIN EVALUATION AND MANAGEMENT SERVICES.

Section 1848 of the Social Security Act (42 U.S.C. 1395w–4), as amended by section 4101 of the HITECH Act (Public Law 111–5), is amended by adding at the end the following new subsection:

''(p) PAYMENT MODIFIER FOR CERTAIN EVALUATION AND MANAGEMENT SERVICES.—The Secretary shall establish a payment modifier under the fee schedule under this section for evaluation and management services (as specified in section 1842(b)(16)(B)(ii)) that result in the ordering of additional services (such as lab tests), the prescription of drugs, the furnishing or ordering of durable medical equipment in order to enable better monitoring of claims for payment for such additional services under this title, or the ordering, furnishing, or prescribing of other items and services determined by the Secretary to pose a high risk of waste, fraud, and abuse. The Secretary may require providers of services or suppliers to report such modifier in claims submitted for payment.''.

SEC. 1634. EVALUATIONS AND REPORTS REQUIRED UNDER MEDICARE INTEGRITY PROGRAM.

(a) IN GENERAL.—Section 1893(c) of the Social Security Act (42 U.S.C. 1395ddd(c)) is amended—

(1) in paragraph (3), by striking at the end ''and'';

(2) by redesignating paragraph (4) as paragraph (5); and

(3) by inserting after paragraph (3) the following new paragraph:

''(4) for the contract year beginning in 2011 and each subsequent contract year, the entity provides assurances to the satisfaction of the Secretary that the entity will conduct periodic evaluations of the effectiveness of the activities carried out by such entity under the Program and will submit to the Secretary an annual report on such activities; and''.

(b) REFERENCE TO MEDICAID INTEGRITY PROGRAM.—For a similar provision with respect to the Medicaid Integrity Program, see section 1752.

SEC. 1635. REQUIRE PROVIDERS AND SUPPLIERS TO ADOPT PROGRAMS TO REDUCE WASTE, FRAUD, AND ABUSE.

(a) IN GENERAL.—Section 1874 of the Social Security Act (42 U.S.C. 42 U.S.C. 1395kk) is amended by adding at the end the following new subsection:

''(d) COMPLIANCE PROGRAMS FOR PROVIDERS OF SERVICES AND SUPPLIERS.—

''(1) IN GENERAL.—The Secretary may disenroll a provider of services or a supplier (other than a physician or a skilled nursing facility) under this title (or may impose any civil monetary penalty or other intermediate sanction under paragraph (4)) if such provider of services or supplier fails to, subject to paragraph (5), establish a compliance pro-

gram that contains the core elements established under paragraph (2).

''(2) ESTABLISHMENT OF CORE ELEMENTS.—The Secretary, in consultation with the Inspector General of the Department of Health and Human Services, shall establish core elements for a compliance program under paragraph (1). Such elements may include written policies, procedures, and standards of conduct, a designated compliance officer and a compliance committee; effective training and education pertaining to fraud, waste, and abuse for the organization's employees and contractors; a confidential or anonymous mechanism, such as a hotline, to receive compliance questions and reports of fraud, waste, or abuse; disciplinary guidelines for enforcement of standards; internal monitoring and auditing procedures, including monitoring and auditing of contractors; procedures for ensuring prompt responses to detected offenses and development of corrective action initiatives, including responses to potential offenses; and procedures to return all identified overpayments to the programs under this title, title XIX, and title XXI.

''(3) TIMELINE FOR IMPLEMENTATION.—The Secretary shall determine a timeline for the estab-

lishment of the core elements under paragraph (2) and the date on which a provider of services and suppliers (other than physicians) shall be required to have established such a program for purposes of this subsection.

''(4) CMS ENFORCEMENT AUTHORITY.—The Administrator for the Centers of Medicare & Medicaid Services shall have the authority to determine whether a provider of services or supplier described in subparagraph (3) has met the requirement of this subsection and to impose a civil monetary penalty not to exceed $50,000 for each violation. The Secretary may also impose other intermediate sanctions, including corrective action plans and additional monitoring in the case of a violation of this subsection.

''(5) PILOT PROGRAM.—The Secretary may conduct a pilot program on the application of this subsection with respect to a category of providers of services or suppliers (other than physicians) that the Secretary determines to be a category which is at high risk for waste, fraud, and abuse before implementing the requirements of this subsection to all providers of services and suppliers described in paragraph (3).''.

(b) REFERENCE TO SIMILAR MEDICAID PROVISION.—For a similar provision with respect to the Medicaid program under title XIX of the Social Security Act, see section 1753.

SEC. 1636. MAXIMUM PERIOD FOR SUBMISSION OF MEDICARE CLAIMS REDUCED TO NOT MORE THAN 12 MONTHS.

(a) PURPOSE.—In general, the 36-month period currently allowed for claims filing under parts A, B, C, and, D of title XVIII of the Social Security Act presents opportunities for fraud schemes in which processing patterns of the Centers for Medicare & Medicaid Services can be observed and exploited. Narrowing the window for claims processing will not overburden providers and will reduce fraud and abuse.

(b) REDUCING MAXIMUM PERIOD FOR SUBMISSION.—

(1) PART A.—Section 1814(a) of the Social Security Act (42 U.S.C. 1395f(a)) is amended—

(A) in paragraph (1), by strikeing ''period of 3 calendar years'' and all that follows and inserting ''period of 1 calendar year from which such services are furnished; and''; and

(B) by adding at the end the following new sentence: ''In applying paragraph (1), the Sec-

retary may specify exceptions to the 1 calendar year period specified in such paragraph.''.

(2) PART B.—Section 1835(a) of such Act (42 U.S.C. 1395n(a)) is amended—

(A) in paragraph (1), by strikeing ''period of 3 calendar years'' and all that follows and inserting ''period of 1 calendar year from which such services are furnished; and''; and

(B) by adding at the end the following new sentence: ''In applying paragraph (1), the Secretary may specify exceptions to the 1 calendar year period specified in such paragraph.''.

(3) PARTS C AND D.—Section 1857(d) of such Act is amended by adding at the end the following new paragraph:

''(7) PERIOD FOR SUBMISSION OF CLAIMS.—The contract shall require an MA organization or PDP sponsor to require any provider of services under contract with, in partnership with, or affiliated with such organization or sponsor to ensure that, with respect to items and services furnished by such provider to an enrollee of such organization, written request, signed by such enrollee, except in cases in which the Secretary finds it impracticable for the enrollee to do so, is filed for payment for

such items and services in such form, in such manner, and by such person or persons as the Secretary may by regulation prescribe, no later than the close of the 1 calendar year period after such items and services are furnished. In applying the previous sentence, the Secretary may specify exceptions to the 1 calendar year period specified.''.

(c) EFFECTIVE DATE.—The amendments made by subsection (b) shall be effective for items and services furnished on or after January 1, 2011.

SEC. 1637. PHYSICIANS WHO ORDER DURABLE MEDICAL EQUIPMENT OR HOME HEALTH SERVICES REQUIRED TO BE MEDICARE ENROLLED PHYSICIANS OR ELIGIBLE PROFESSIONALS.

(a) DME.—Section 1834(a)(11)(B) of the Social Security Act (42 U.S.C. 1395m(a)(11)(B)) is amended by striking ''physician'' and inserting ''physician enrolled under section 1866(j) or an eligible professional under section 1848(k)(3)(B)''.

(b) HOME HEALTH SERVICES.—

(1) PART A.—Section 1814(a)(2) of such Act (42 U.S.C. 1395(a)(2)) is amended in the matter preceding subparagraph (A) by inserting ''in the case of services described in subparagraph (C), a physician enrolled under section 1866(j) or an eligi-

ble professional under section 1848(k)(3)(B),'' before ''or, in the case of services''.

(2) PART B.—Section 1835(a)(2) of such Act (42 U.S.C. 1395n(a)(2)) is amended in the matter preceding subparagraph (A) by inserting '', or in the case of services described in subparagraph (A), a physician enrolled under section 1866(j) or an eligible professional under section 1848(k)(3)(B),'' after ''a physician''.

(c) DISCRETION TO EXPAND APPLICATION.—The Secretary may extend the requirement applied by the amendments made by subsections (a) and (b) to durable medical equipment and home health services (relating to requiring certifications and written orders to be made by enrolled physicians and health professions) to other categories of items or services under this title, including covered part D drugs as defined in section 1860D–2(e), if the Secretary determines that such application would help to reduce the risk of waste, fraud, and abuse with respect to such other categories under title XVIII of the Social Security Act.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to written orders and certifications made on or after July 1, 2010.

SEC. 1638. REQUIREMENT FOR PHYSICIANS TO PROVIDE DOCUMENTATION ON REFERRALS TO PROGRAMS AT HIGH RISK OF WASTE AND ABUSE.

(a) PHYSICIANS AND OTHER SUPPLIERS.—Section 1842(h) of the Social Security Act, as amended by section 1635, is further amended by adding at the end the following new paragraph

''(10) The Secretary may disenroll, for a period of not more than one year for each act, a physician or supplier under section 1866(j) if such physician or supplier fails to maintain and, upon request of the Secretary, provide access to documentation relating to written orders or requests for payment for durable medical equipment, certifications for home health services, or referrals for other items or services written or ordered by such physician or supplier under this title, as specified by the Secretary.''.

(b) PROVIDERS OF SERVICES.—Section 1866(a)(1) of such Act (42 U.S.C. 1395cc), as amended by section 1635, is further amended—

(1) in subparagraph (V), by striking at the end ''and'';

(2) in subparagraph (W), by striking the period at the end and adding ''; and''; and

(3) by adding at the end the following new subparagraph:

''(X) maintain and, upon request of the Secretary, provide access to documentation relating to written orders or requests for payment for durable medical equipment, certifications for home health services, or referrals for other items or services written or ordered by the provider under this title, as specified by the Secretary.''.

(c) OIG PERMISSIVE EXCLUSION AUTHORITY.—Section 1128(b)(11) of the Social Security Act (42 U.S.C. 1320a–7(b)(11)) is amended by inserting '', ordering, referring for furnishing, or certifying the need for'' after ''furnishing''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to orders, certifications, and referrals made on or after January 1, 2010.

SEC. 1639. FACE TO FACE ENCOUNTER WITH PATIENT REQUIRED BEFORE PHYSICIANS MAY CERTIFY ELIGIBILITY FOR HOME HEALTH SERVICES OR DURABLE MEDICAL EQUIPMENT UNDER MEDICARE.

(a) CONDITION OF PAYMENT FOR HOME HEALTH SERVICES.—

(1) PART A.—Section 1814(a)(2)(C) of such Act is amended—

(A) by striking ''and such services'' and inserting ''such services''; and

(B) by inserting after ''care of a physician'' the following: '', and, in the case of a certification or recertification made by a physician after January 1, 2010, prior to making such certification the physician must document that the physician has had a face-to-face encounter (including through use of telehealth and other than with respect to encounters that are incident to services involved) with the individual during the 6-month period preceding such certification, or other reasonable timeframe as determined by the Secretary''.

(2) PART B.—Section 1835(a)(2)(A) of the Social Security Act is amended—

(A) by striking ''and'' before ''(iii)''; and

(B) by inserting after ''care of a physician'' the following: '', and (iv) in the case of a certification or recertification after January 1, 2010, prior to making such certification the physician must document that the physician has had a face-to-face encounter (including through use of telehealth and other than with respect to encounters that are incident to services in-

volved) with the individual during the 6-month period preceding such certification or recertification, or other reasonable timeframe as determined by the Secretary''.

(b) CONDITION OF PAYMENT FOR DURABLE MEDICAL EQUIPMENT.—Section 1834(a)(11)(B) of the Social Security Act (42 U.S.C. 1395m(a)(11)(B)) is amended by adding at the end the following: ''and shall require that such an order be written pursuant to the physician documenting that the physician has had a face-to-face encounter (including through use of telehealth and other than with respect to encounters that are incident to services involved) with the individual involved during the 6-month period preceding such written order, or other reasonable timeframe as determined by the Secretary''.

(c) APPLICATION TO OTHER AREAS UNDER MEDICARE.—The Secretary may apply the face-to-face encounter requirement described in the amendments made by subsections (a) and (b) to other items and services for which payment is provided under title XVIII of the Social Security Act based upon a finding that such an decision would reduce the risk of waste, fraud, or abuse.

(d) APPLICATION TO MEDICAID AND CHIP.—The requirements pursuant to the amendments made by subsections (a) and (b) shall apply in the case of physicians

making certifications for home health services under title XIX or XXI of the Social Security Act, in the same manner and to the same extent as such requirements apply in the case of physicians making such certifications under title XVIII of such Act.

SEC. 1640. EXTENSION OF TESTIMONIAL SUBPOENA AUTHORITY TO PROGRAM EXCLUSION INVESTIGATIONS.

(a) IN GENERAL.—Section 1128(f) of the Social Security Act (42 U.S.C. 1320a-7(f)) is amended by adding at the end the following new paragraph:

''(4) The provisions of subsections (d) and (e) of section 205 shall apply with respect to this section to the same extent as they are applicable with respect to title II. The Secretary may delegate the authority granted by section 205(d) (as made applicable to this section) to the Inspector General of the Department of Health and Human Services or the Administrator of the Centers for Medicare & Medicaid Services for purposes of any investigation under this section.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to investigations beginning on or after January 1, 2010.

SEC. 1641. REQUIRED REPAYMENTS OF MEDICARE AND MEDICAID OVERPAYMENTS.

Section 1128G of the Social Security Act, as inserted by section 1631 and amended by section 1632, is further amended by adding at the end the following new subsection:

''(c) REPORTS ON AND REPAYMENT OF OVERPAYMENTS IDENTIFIED THROUGH INTERNAL AUDITS AND REVIEWS.—

''(1) REPORTING AND RETURNING OVERPAYMENTS.—If a person knows of an overpayment, the person must—

''(A) report and return the overpayment to the Secretary, the State, an intermediary, a carrier, or a contractor, as appropriate, at the correct address, and

''(B) notify the Secretary, the State, intermediary, carrier, or contractor to whom the overpayment was returned in writing of the reason for the overpayment.

''(2) TIMING.—An overpayment must be reported and returned under paragraph (1)(A) by not later than the date that is 60 days after the date the person knows of the overpayment.

Any known overpayment retained later than the applicable date specified in this paragraph creates an

obligation as defined in section 3729(b)(3) of title 31 of the United States Code.

''(3) CLARIFICATION.—Repayment of any overpayments (or refunding by withholding of future payments) by a provider of services or supplier does not otherwise limit the provider or supplier's potential liability for administrative obligations such as applicable interests, fines, and specialties or civil or criminal sanctions involving the same claim if it is determined later that the reason for the overpayment was related to fraud by the provider or supplier or the employees or agents of such provider or supplier.

''(4) DEFINITIONS.—In this subsection:

''(A) KNOWS.—The term 'knows' has the meaning given the terms 'knowing' and 'knowingly' in section 3729(b) of title 31 of the United States Code.

''(B) OVERPAYMENT.—The term ''overpayment'' means any finally determined funds that a person receives or retains under title XVIII, XIX, or XXI to which the person, after applicable reconciliation, is not entitled under such title.

''(C) PERSON.—The term 'person' means a provider of services, supplier, Medicaid managed care organization (as defined in section 1903(m)(1)(A)), Medicare Advantage organization (as defined in section 1859(a)(1)), or PDP sponsor (as defined in section 1860D–41(a)(13)), but excluding a beneficiary.''.

SEC. 1642. EXPANDED APPLICATION OF HARDSHIP WAIVERS FOR OIG EXCLUSIONS TO BENEFICIARIES OF ANY FEDERAL HEALTH CARE PROGRAM.

Section 1128(c)(3)(B) of the Social Security Act (42 U.S.C. 1320a–7(c)(3)(B)) is amended by striking ''individuals entitled to benefits under part A of title XVIII or enrolled under part B of such title, or both'' and inserting ''beneficiaries (as defined in section 1128A(i)(5)) of that program''.

SEC. 1643. ACCESS TO CERTAIN INFORMATION ON RENAL DIALYSIS FACILITIES.

Section 1881(b) of the Social Security Act (42 U.S.C. 1395rr(b)) is amended by adding at the end the following new paragraph:

''(15) For purposes of evaluating or auditing payments made to renal dialysis facilities for items and services under this section under paragraph (1), each such

renal dialysis facility, upon the request of the Secretary, shall provide to the Secretary access to information relating to any ownership or compensation arrangement between such facility and the medical director of such facility or between such facility and any physician.''.

SEC. 1644. BILLING AGENTS, CLEARINGHOUSES, OR OTHER ALTERNATE PAYEES REQUIRED TO REGISTER UNDER MEDICARE.

(a) MEDICARE.—Section 1866(j)(1) of the Social Security Act (42 U.S.C. 1395cc(j)(1)) is amended by adding at the end the following new subparagraph:

''(D) BILLING AGENTS AND CLEARINGHOUSES REQUIRED TO BE REGISTER UNDER MEDICARE.—Any agent, clearinghouse, or other alternate payee that submits claims on behalf of a health care provider must be registered with the Secretary in a form and manner specified by the Secretary.''.

(b) MEDICAID.—For a similar provision with respect to the Medicaid program under title XIX of the Social Security Act, see section 1759.

(c) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to claims submitted on or after January 1, 2012.

SEC. 1645. CONFORMING CIVIL MONETARY PENALTIES TO FALSE CLAIMS ACT AMENDMENTS.

Section 1128A of the Social Security Act, as amended by sections 1611, 1612, 1613, and 1615, is further amended—

(1) in subsection (a)—

(A) in paragraph (1), by striking ''to an officer, employee, or agent of the United States, or of any department or agency thereof, or of any State agency (as defined in subsection (i)(1))'';

(B) in paragraph (4)—

(i) by striking ''participating in a program under title XVIII or a State health care program'' and inserting ''participating in a Federal health care program (as defined in section 1128B(f))''; and

(ii) in subparagraph (A), by striking ''title XVIII or a State health care program'' and inserting ''a Federal health care program (as defined in section 1128B(f))'';

(C) by striking ''or'' at the end of paragraph (10);

(D) by inserting after paragraph (11) the following new paragraphs:

''(12) conspires to commit a violation of this section; or

''(13) knowingly makes, uses, or causes to be made or used, a false record or statement material to an obligation to pay or transmit money or property to a Federal health care program, or knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to a Federal health care program;''; and

(E) in the matter following paragraph (13), as inserted by subparagraph (D), by striking ''or in cases under paragraph (11), $50,000 for each such violation'' and inserting ''in cases under paragraph (11), $50,000 for each such violation, in cases under paragraph (12), $50,000 for any violation described in this section committed in furtherance of the conspiracy involved; or in cases under paragraph (13), $50,000 for each false record or statement, or concealment, avoidance, or decrease''; and

(F) in the second sentence, by striking ''such false statement or misrepresentation)'' and inserting ''such false statement or misrepresentation, in cases under paragraph (12), an assessment of not more than 3 times the

total amount that would otherwise apply for any violation described in this section committed in furtherance of the conspiracy involved, or in cases under paragraph (13), an assessment of not more than 3 times the total amount of the obligation to which the false record or statment was material or that was avoided or decreased)''.

(2) in subsection (c)(1), by striking ''six years'' and inserting ''10 years''; and

(3) in subsection (i)—

(A) by amending paragraph (2) to read as follows:

''(2) The term ''claim'' means any application, request, or demand, whether under contract, or otherwise, for money or property for items and services under a Federal health care program (as defined in section 1128B(f)), whether or not the United States or a State agency has title to the money or property, that—

''(A) is presented or caused to be presented to an officer, employee, or agent of the United States, or of any department or agency thereof, or of any State agency (as defined in subsection (i)(1)); or

''(B) is made to a contractor, grantee, or other recipient if the money or property is to be spent or used on the Federal health care program's behalf or to advance a Federal health care program interest, and if the Federal health care program—

''(i) provides or has provided any portion of the money or property requested or demanded; or

''(ii) will reimburse such contractor, grantee, or other recipient for any portion of the money or property which is requested or demanded.'';

(B) by amending paragraph (3) to read as follows:

''(3) The term 'item or service' means, without limitation, any medical, social, management, administrative, or other item or service used in connection with or directly or indirectly related to a Federal health care program.'';

(C) in paragraph (6)—

(i) in subparagraph (C), by striking at the end ''or'';

(ii) in the first subparagraph (D), by striking at the end the period and inserting ''; or''; and

(iii) by redesignating the second subparagraph (D) as a subparagraph (E);

(D) by amending paragraph (7) to read as follows:

''(7) The terms 'knowing', 'knowingly', and 'should know' mean that a person, with respect to information—

''(A) has actual knowledge of the information;

''(B) acts in deliberate ignorance of the truth or falsity of the information; or

''(C) acts in reckless disregard of the truth or falsity of the information;

and require no proof of specific intent to defraud.''; and

(E) by adding at the end the following new paragraphs:

''(8) The term 'obligation' means an established duty, whether or not fixed, arising from an express or implied contractual, grantor-grantee, or licensor-licensee relationship, from a fee-based or similar re-

lationship, from statute or regulation, or from the retention of any overpayment.

''(9) The term 'material' means having a natural tendency to influence, or be capable of influencing, the payment or receipt of money or property.''.

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

SEC. 1651. ACCESS TO INFORMATION NECESSARY TO IDENTIFY FRAUD, WASTE, AND ABUSE.

Section 1128G of the Social Security Act, as added by section 1631 and amended by sections 1632 and 1641, is further amended by adding at the end the following new subsection;

''(d) ACCESS TO INFORMATION NECESSARY TO IDENTIFY FRAUD, WASTE, AND ABUSE.—For purposes of law enforcement activity, and to the extent consistent with applicable disclosure, privacy, and security laws, including the Health Insurance Portability and Accountability Act of 1996 and the Privacy Act of 1974, and subject to any information systems security requirements enacted by law or otherwise required by the Secretary, the Attorney General shall have access, facilitation by the Inspector General of the Department of Health and Human Services, to

claims and payment data relating to titles XVIII and XIX, in consultation with the Centers for Medicare & Medicaid Services or the owner of such data.''.

SEC. 1652. ELIMINATION OF DUPLICATION BETWEEN THE HEALTHCARE INTEGRITY AND PROTECTION DATA BANK AND THE NATIONAL PRACTITIONER DATA BANK.

(a) IN GENERAL.—To eliminate duplication between the Healthcare Integrity and Protection Data Bank (HIPDB) established under section 1128E of the Social Security Act and the National Practitioner Data Bank (NPBD) established under the Health Care Quality Improvement Act of 1986, section 1128E of the Social Security Act (42 U.S.C. 1320a-7e) is amended—

(1) in subsection (a), by striking ''Not later than'' and inserting ''Subject to subsection (h), not later than'';

(2) in the first sentence of subsection (d)(2), by striking ''(other than with respect to requests by Federal agencies)''; and

(3) by adding at the end the following new subsection:

''(h) SUNSET OF THE HEALTHCARE INTEGRITY AND PROTECTION DATA BANK; TRANSITION PROCESS.—Effective upon the enactment of this subsection, the Sec-

retary shall implement a process to eliminate duplication between the Healthcare Integrity and Protection Data Bank (in this subsection referred to as the 'HIPDB' established pursuant to subsection (a) and the National Practitioner Data Bank (in this subsection referred to as the 'NPDB') as implemented under the Health Care Quality Improvement Act of 1986 and section 1921 of this Act, including systems testing necessary to ensure that information formerly collected in the HIPDB will be accessible through the NPDB, and other activities necessary to eliminate duplication between the two data banks. Upon the completion of such process, notwithstanding any other provision of law, the Secretary shall cease the operation of the HIPDB and shall collect information required to be reported under the preceding provisions of this section in the NPDB. Except as otherwise provided in this subsection, the provisions of subsections (a) through (g) shall continue to apply with respect to the reporting of (or failure to report), access to, and other treatment of the information specified in this section..''.

(b) ELIMINATION OF THE RESPONSIBILITY OF THE HHS OFFICE OF THE INSPECTOR GENERAL.—Section 1128C(a)(1) of the Social Security Act (42 U.S.C. 1320a-7c(a)(1)) is amended—

(1) in subparagraph (C), by adding at the end ''and'';

(2) in subparagraph (D), by striking at the end '', and'' and inserting a period; and

(3) by striking subparagraph (E).

(c) SPECIAL PROVISION FOR ACCESS TO THE NATIONAL PRACTITIONER DATA BANK BY THE DEPARTMENT OF VETERANS AFFAIRS.—

(1) IN GENERAL.—Notwithstanding any other provision of law, during the one year period that begins on the effective date specified in subsection (e)(1), the information described in paragraph (2) shall be available from the National Practitioner Data Bank (described in section 1921 of the Social Security Act) to the Secretary of Veterans Affairs without charge.

(2) INFORMATION DESCRIBED.—For purposes of paragraph (1), the information described in this paragraph is the information that would, but for the amendments made by this section, have been available to the Secretary of Veterans Affairs from the Healthcare Integrity and Protection Data Bank.

(d) FUNDING.—Notwithstanding any provisions of this Act, sections 1128E(d)(2) and 1817(k)(3) of the Social Security Act, or any other provision of law, there shall

be available for carrying out the transition process under section 1128E(h) of the Social Security Act over the period required to complete such process, and for operation of the National Practitioner Data Bank until such process is completed, without fiscal year limitation—

(1) any fees collected pursuant to section 1128E(d)(2) of such Act; and

(2) such additional amounts as necessary, from appropriations available to the Secretary and to the Office of the Inspector General of the Department of Health and Human Services under clauses (i) and (ii), respectively, of section 1817(k)(3)(A) of such Act, for costs of such activities during the first 12 months following the date of the enactment of this Act.

(e) EFFECTIVE DATE.—The amendments made—

(1) by subsection (a)(2) shall take effect on the first day after the Secretary of Health and Human Services certifies that the process implemented pursuant to section 1128E(h) of the Social Security Act (as added by subsection (a)(3)) is complete; and

(2) by subsection (b) shall take effect on the earlier of the date specified in paragraph (1) or the first day of the second succeeding fiscal year after the fiscal year during which this Act is enacted.

SEC. 1653. COMPLIANCE WITH HIPAA PRIVACY AND SECURITY STANDARDS.

The provisions of sections 262(a) and 264 of the Health Insurance Portability and Accountability Act of 1996 (and standards promulgated pursuant to such sections) and the Privacy Act of 1974 shall apply with respect to the provisions of this subtitle and amendments made by this subtitle.

TITLE VII—MEDICAID AND CHIP

Subtitle A—Medicaid and Health Reform

SEC. 1701. ELIGIBILITY FOR INDIVIDUALS WITH INCOME BELOW 133-⅓ PERCENT OF THE FEDERAL POVERTY LEVEL.

(a) ELIGIBILITY FOR NON-TRADITIONAL INDIVIDUALS WITH INCOME BELOW 133 PERCENT OF THE FEDERAL POVERTY LEVEL.—

(1) IN GENERAL.—Section 1902(a)(10)(A)(i) of the Social Security Act (42 U.S.C. 1396b(a)(10)(A)(i) is amended—

(A) by striking ''or'' at the end of subclause (VI);

(B) by adding ''or'' at the end of subclause (VII); and

(C) by adding at the end the following new subclause:

''(VIII) who are under 65 years of age, who are not described in a previous subclause of this clause, and who are in families whose income (determined using methodologies and procedures specified by the Secretary in consultation with the Health Choices Commissioner) does not exceed 133 ⅓ percent of the income official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved;''.

(2) 100% FMAP FOR NON-TRADITIONAL MEDICAID ELIGIBLE INDIVIDUALS.—Section 1905 of such Act (42 U.S.C. 1396d) is amended—

(A) in the third sentence of subsection (b) by inserting before the period at the end the following: ''and with respect to amounts described in subsection (y)''; and

(B) by adding at the end the following new subsection:

''(y) ADDITIONAL EXPENDITURES SUBJECT TO 100% FMAP.—For purposes of section 1905(b), the amounts described in this subsection are the following:

''(1) Amounts expended for medical assistance for individuals described in subclause (VIII) of section 1902(a)(10)(A)(i).''.

(3) CONSTRUCTION.—Nothing in this subsection shall be construed as not providing for coverage under subclause (VIII) of section 1902(a)(10)(A)(i) of the Social Security Act, as added by paragraph (1) of, and an increased FMAP under the amendment made by paragraph (2) for, an individual who has been provided medical assistance under title XIX of the Act under a demonstration waiver approved under section 1115 of such Act or with State funds.

(4) CONFORMING AMENDMENT.—Section 1903(f)(4) of the Social Security Act (42 U.S.C. 1396b(f)(4)) is amended by inserting ''1902(a)(10)(A)(i)(VIII),'' after ''1902(a)(10)(A)(i)(VII),''.

(b) ELIGIBILITY FOR TRADITIONAL MEDICAID ELIGIBLE INDIVIDUALS WITH INCOME NOT EXCEEDING 133-⅓ PERCENT OF THE FEDERAL POVERTY LEVEL .—

(1) IN GENERAL.—Section 1902(a)(10)(A)(i) of the Social Security Act (42 U.S.C. 1396b(a)(10)(A)(i)), as amended by subsection (a), is amended—

(A) by striking ''or'' at the end of subclause (VII);

(B) by adding ''or'' at the end of subclause (VIII); and

(C) by adding at the end the following new subclause:

''(IX) who are under 65 years of age, who would be eligible for medical assistance under the State plan under one of subclauses (I) through (VII) (based on the income standards, methodologies, and procedures in effect as of June 16, 2009) but for income and who are in families whose income does not exceed 133⅓ percent of the income official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of

1981) applicable to a family of the size involved;''.

(2) 100% FMAP FOR CERTAIN TRADITIONAL MEDICAID ELIGIBLE INDIVIDUALS.—Section 1905(y) of such Act (42 U.S.C. 1396d(b)), as added by subsection (a)(2)(B), is amended by inserting ''or (IX)'' after ''(VIII)''.

(3) CONSTRUCTION.—Nothing in this subsection shall be construed as not providing for coverage under subclause (IX) of section 1902(a)(10)(A)(i) of the Social Security Act, as added by paragraph (1) of, and an increased FMAP under the amendment made by paragraph (2) for, an individual who has been provided medical assistance under title XIX of the Act under a demonstration waiver approved under section 1115 of such Act or with State funds.

(4) CONFORMING AMENDMENT.—Section 1903(f)(4) of the Social Security Act (42 U.S.C. 1396b(f)(4)), as amended by subsection (a)(4), is amended by inserting ''1902(a)(10)(A)(i)(IX),'' after ''1902(a)(10)(A)(i)(VIII),''.

(c) 100% MATCHING RATE FOR TEMPORARY COVERAGE OF CERTAIN NEWBORNS.—Section 1905(y) of such Act, as added by subsection (a)(2)(B), is amended—

(1) in paragraph (1), by inserting before the period at the end the following: ", and who is not provided medical assistance under section 1943(b)(2) of this title or section 205(d)(1)(B) of the America's Affordable Health Choices Act of 2009"; and

(2) by adding at the end the following:

"(2) Amounts expended for medical assistance for children described in section 203(d)(1)(A) of the America's Affordable Health Choices Act of 2009 during the time period specified in such section.".

(d) NETWORK ADEQUACY.—Section 1932(a)(2) of the Social Security Act (42 U.S.C. 1396u–2(a)(2)) is amended by adding at the end the following new subparagraph:

"(D) ENROLLMENT OF NON-TRADITIONAL MEDICAID ELIGIBLES.—A State may not require under paragraph (1) the enrollment in a managed care entity of an individual described in section 1902(a)(10)(A)(i)(VIII) unless the State demonstrates, to the satisfaction of the Secretary, that the entity, through its provider network and other arrangements, has the capacity to meet the health, mental health, and substance abuse needs of such individuals.".

(e) EFFECTIVE DATE.—The amendments made by this section shall take effect on the first day of Y1, and shall apply with respect to items and services furnished on or after such date.

SEC. 1702. REQUIREMENTS AND SPECIAL RULES FOR CERTAIN MEDICAID ELIGIBLE INDIVIDUALS.

(a) IN GENERAL.—Title XIX of the Social Security Act is amended by adding at the end the following new section:

" REQUIREMENTS AND SPECIAL RULES FOR CERTAIN MEDICAID ELIGIBLE INDIVIDUALS

"SEC. 1943. (a) COORDINATION WITH NHI EXCHANGE THROUGH MEMORANDUM OF UNDERSTANDING.—

"(1) IN GENERAL.—The State shall enter into a Medicaid memorandum of understanding described in section 204(e)(4) of the America's Affordable Health Choices Act of 2009 with the Health Choices Commissioner, acting in consultation with the Secretary, with respect to coordinating the implementation of the provisions of division A of such Act with the State plan under this title in order to ensure the enrollment of Medicaid eligible individuals in acceptable coverage. Nothing in this section shall be construed as permitting such memorandum to modify or

vitiate any requirement of a State plan under this title.

''(2) ENROLLMENT OF EXCHANGE-REFERRED INDIVIDUALS.—

''(A) NON-TRADITIONAL INDIVIDUALS.—Pursuant to such memorandum the State shall accept without further determination the enrollment under this title of an individual determined by the Commissioner to be a non-traditional Medicaid eligible individual. The State shall not do any redeterminations of eligibility for such individuals unless the periodicity of such redeterminations is consistent with the periodicity for redeterminations by the Commissioner of eligibility for affordability credits under subtitle C of title II of division A of the America's Affordable Health Choices Act of 2009, as specified under such memorandum.

''(B) TRADITIONAL INDIVIDUALS.—

''(i) REGULAR ENROLLMENT OPTION.—Pursuant to such memorandum, insofar as the memorandum has selected the option described in section 205(e)(3)(A) of the America's Affordable Health Choices Act of 2009, the State

shall accept without further determination the enrollment under this title of an individual determined by the Commissioner to be a traditional Medicaid eligible individual. The State may do redeterminations of eligibility of such individual consistent with such section and the memorandum.

''(ii) PRESUMPTIVE ELIGIBILITY OPTION.—Pursuant to such memorandum, insofar as the memorandum has selected the option described in section 205(e)(3)(B) of the America's Affordable Health Choices Act of 2009, the State shall provide for making medical assistance available during the presumptive eligibility period and shall, upon application of the individual for medical assistance under this title, promptly make a determination (and subsequent redeterminations) of eligibility in the same manner as if the individual had applied directly to the State for such assistance except that the State shall use the income-related information used by the Commissioner and provided to the State under the memorandum in making the pre-

sumptive eligibility determination to the maximum extent feasible.

''(3) DETERMINATIONS OF ELIGIBILITY FOR AFFORDABILITY CREDITS.—If the Commissioner determines that a State Medicaid agency has the capacity to make determinations of eligibility for affordability credits under subtitle C of title II of division A of the America's Affordable Health Choices Act of 2009, under such memorandum—

''(A) the State Medicaid agency shall conduct such determinations for any Exchange-eligible individual who requests such a determination;

''(B) in the case that a State Medicaid agency determines that an Exchange-eligible individual is not eligible for affordability credits, the agency shall forward the information on the basis of which such determination was made to the Commissioner; and

''(C) the Commissioner shall reimburse the State Medicaid agency for the costs of conducting such determinations.

''(b) TREATMENT OF CERTAIN NEWBORNS.—

''(1) IN GENERAL.—In the case of a child who is deemed under section 205(d)(1) of the America's

Affordable Health Choices Act of 2009 to be a non-traditional Medicaid eligible individual and enrolled under this title pursuant to such section, the State shall provide for a determination, by not later than the end of the period referred to in subparagraph (A) of such section, of the child's eligibility for medical assistance under this title.

''(2) EXTENDED TREATMENT AS TRADITIONAL MEDICAID ELIGIBLE INDIVIDUAL.—In accordance with subparagraph (B) of section 205(d)(1) of the America's Affordable Health Choices Act of 2009, in the case of a child described in subparagraph (A) of such section who at the end of the period referred to in such subparagraph is not otherwise covered under acceptable coverage, the child shall be deemed (until such time as the child obtains such coverage or the State otherwise makes a determination of the child's eligibility for medical assistance under its plan under this title pursuant to paragraph (1)) to be a traditional Medicaid eligible individual described in section 1902(l)(1)(B).

''(c) DEFINITIONS .—In this section:

''(1) MEDICAID ELIGIBLE INDIVIDUALS.—In this section, the terms 'Medicaid eligible individual', 'traditional Medicaid eligible individual', and 'non-

traditional Medicaid eligible individual' have the meanings given such terms in section 205(e)(5) of the America's Affordable Health Choices Act of 2009.

''(2) MEMORANDUM.—The term 'memorandum' means a Medicaid memorandum of understanding under section 205(e)(4) of the America's Affordable Health Choices Act of 2009.

''(3) Y1.—The term 'Y1' has the meaning given such term in section 100(c) of the America's Affordable Health Choices Act of 2009.''.

(b) CONFORMING AMENDMENTS TO ERROR RATE.—

(1) Section 1903(u)(1)(D) of the Social Security Act (42 U.S.C. 1396b(u)(1)(D)) is amended by adding at the end the following new clause:

''(vi) In determining the amount of erroneous excess payments, there shall not be included any erroneous payments made that are attributable to an error in an eligibility determination under subtitle C of title II of division A of the America's Affordable Health Choices Act of 2009.''.

(2) Section 2105(c)(11) of such Act (42 U.S.C. 1397ee(c)(11)) is amended by adding at the end the following new sentence: ''Clause (vi) of section 1903(u)(1)(D) shall apply with respect to the appli-

cation of such requirements under this title and title XIX.''.

SEC. 1703. CHIP AND MEDICAID MAINTENANCE OF EFFORT.

(a) CHIP MAINTENANCE OF EFFORT.—Section 1902 of the Social Security Act (42 U.S.C. 1396a) is amended—

(1) in subsection (a), as amended by section 1631(b)(1)(D)—

(A) by striking ''and'' at the end of paragraph (72);

(B) by striking the period at the end of paragraph (73) and inserting ''; and''; and

(C) by inserting after paragraph (74) the following new paragraph:

''(75) provide for maintenance of effort under the State child health plan under title XXI in accordance with subsection (gg).''; and

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

''(gg) CHIP MAINTENANCE OF EFFORT REQUIREMENT.—

''(1) IN GENERAL.—Subject to paragraph (2), as a condition of its State plan under this title under subsection (a)(75) and receipt of any Federal financial assistance under section 1903(a) for calendar

quarters beginning after the date of the enactment of this subsection and before CHIP MOE termination date specified in paragraph (3), a State shall not have in effect eligibility standards, methodologies, or procedures under its State child health plan under title XXI (including any waiver under such title or under section 1115 that is permitted to continue effect) that are more restrictive than the eligibility standards, methodologies, or procedures, respectively, under such plan (or waiver) as in effect on June 16, 2009.

''(2) LIMITATION.—Paragraph (1) shall not be construed as preventing a State from imposing a limitation described in section 2110(b)(5)(C)(i)(II) for a fiscal year in order to limit expenditures under its State child health plan under title XXI to those for which Federal financial participation is available under section 2105 for the fiscal year.

''(3) CHIP MOE TERMINATION DATE.—In paragraph (1), the 'CHIP MOE termination date' for a State is the date that is the first day of Y1 (as defined in section 100(c) of the America's Affordable Health Choices Act of 2009) or, if later, the first day after such date that both of the following determinations have been made:

''(A) The Health Choices Commissioner has determined that the Health Insurance Exchange has the capacity to support the participation of CHIP enrollees who are Exchange-eligible individuals (as defined in section 202(b) of the America's Affordable Health Choices Act of 2009),

''(B) The Secretary has determined that such Exchange, the State, and employers have procedures in effect to ensure the timely transition without interruption of coverage of CHIP enrollees from assistance under title XXI to acceptable coverage (as defined for purposes of such Act).

In this paragraph, the term 'CHIP enrollee' means a targeted low-income child or (if the State has elected the option under section 2112, a targeted low-income pregnant woman) who is or otherwise would be (but for acceptable coverage) eligible for child health assistance or pregnancy-related assistance, respectively, under the State child health plan referred to in paragraph (1).''.

(b) MEDICAID MAINTENANCE OF EFFORT; SIMPLIFYING AND COORDINATING ELIGIBILITY RULES BETWEEN EXCHANGE AND MEDICAID.—

(1) IN GENERAL.—Section 1903 of such Act (42 U.S.C. 1396b) is amended by adding at the end the following new subsection:

''(aa) MAINTENANCE OF MEDICAID EFFORT; SIMPLIFYING AND COORDINATING ELIGIBILITY RULES BETWEEN HEALTH INSURANCE EXCHANGE AND MEDICAID.—

''(1) MAINTENANCE OF EFFORT.—A State is not eligible for payment under subsection (a) for a calendar quarter beginning after the date of the enactment of this subsection if eligibility standards, methodologies, or procedures under its plan under this title (including any waiver under this title or under section 1115 that is permitted to continue effect) that are more restrictive than the eligibility standards, methodologies, or procedures, respectively, under such plan (or waiver) as in effect on June 16, 2009. The Secretary shall extend such a waiver (including the availability of Federal financial participation under such waiver) for such period as may be required for a State to meet the requirement of the previous sentence.

''(2) REMOVAL OF ASSET TEST FOR CERTAIN ELIGIBILITY CATEGORIES.—

''(A) IN GENERAL.—A State is not eligible for payment under subsection (a) for a calendar quarter beginning on or after the first day of Y1 (as defined in section 100(c) of the America's Affordable Health Choices Act of 2009), if the State applies any asset or resource test in determining (or redetermining) eligibility of any individual on or after such first day under any of the following:

''(i) Subclause (I), (III), (IV), or (VI) of section 1902(a)(10)(A)(i).

''(ii) Subclause (II), (IX), (XIV) or (XVII) of section 1902(a)(10)(A)(ii).

''(iii) Section 1931(b).

''(B) OVERRIDING CONTRARY PROVISIONS; REFERENCES.—The provisions of this title that prevent the waiver of an asset or resource test described in subparagraph (A) are hereby waived.

''(C) REFERENCES.—Any reference to a provision described in a provision in subparagraph (A) shall be deemed to be a reference to such provision as modified through the application of subparagraphs (A) and (B).''.

(2) CONFORMING AMENDMENTS.—(A) Section 1902(a)(10)(A) of such Act (42 U.S.C. 1396a(a)(10)(A)) is amended, in the matter before clause (i), by inserting ''subject to section 1903(aa)(2),'' after ''(A)''.

(B) Section 1931(b)(2) of such Act (42 U.S.C. 1396u–1(b)(1)) is amended by inserting ''subject to section 1903(aa)(2)'' after ''and (3)''.

(c) STANDARDS FOR BENCHMARK PACKAGES.—Section 1937(b) of such Act (42 U.S.C. 1396u–7(b)) is amended—

(1) in paragraph (1), by inserting ''subject to paragraph (5)''; and

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

''(5) MINIMUM STANDARDS.—Effective January 1, 2013, any benchmark benefit package (or benchmark equivalent coverage under paragraph (2)) must meet the minimum benefits and cost-sharing standards of a basic plan offered through the Health Insurance Exchange.''.

SEC. 1704. REDUCTION IN MEDICAID DSH.

(a) REPORT.—

(1) IN GENERAL.—Not later than January 1, 2016, the Secretary of Health and Human Services

(in this title referred to as the ''Secretary'') shall submit to Congress a report concerning the extent to which, based upon the impact of the health care reforms carried out under division A in reducing the number of uninsured individuals, there is a continued role for Medicaid DSH. In preparing the report, the Secretary shall consult with community-based health care networks serving low-income beneficiaries.

(2) MATTERS TO BE INCLUDED.—The report shall include the following:

(A) RECOMMENDATIONS.—Recommendations regarding—

(i) the appropriate targeting of Medicaid DSH within States; and

(ii) the distribution of Medicaid DSH among the States.

(B) SPECIFICATION OF DSH HEALTH REFORM METHODOLOGY.—The DSH Health Reform methodology described in paragraph (2) of subsection (b) for purposes of implementing the requirements of such subsection.

(3) COORDINATION WITH MEDICARE DSH REPORT.—The Secretary shall coordinate the report

under this subsection with the report on Medicare DSH under section 1112.

(4) MEDICAID DSH.—In this section, the term ''Medicaid DSH'' means adjustments in payments under section 1923 of the Social Security Act for inpatient hospital services furnished by disproportionate share hospitals.

(b) MEDICAID DSH REDUCTIONS.—

(1) IN GENERAL.—The Secretary shall reduce Medicaid DSH so as to reduce total Federal payments to all States for such purpose by $1,500,000,000 in fiscal year 2017, $2,500,000,000 in fiscal year 2018, and $6,000,000,000 in fiscal year 2019.

(2) DSH HEALTH REFORM METHODOLOGY.—The Secretary shall carry out paragraph (1) through use of a DSH Health Reform methodology issued by the Secretary that imposes the largest percentage reductions on the States that—

(A) have the lowest percentages of uninsured individuals (determined on the basis of audited hospital cost reports) during the most recent year for which such data are available; or

(B) do not target their DSH payments on—

(i) hospitals with high volumes of Medicaid inpatients (as defined in section 1923(b)(1)(A) of the Social Security Act (42 U.S.C. 1396r–4(b)(1)(A)); and

(ii) hospitals that have high levels of uncompensated care (excluding bad debt).

(3) DSH ALLOTMENT PUBLICATIONS.—

(A) IN GENERAL.—Not later than the publication deadline specified in subparagraph (B), the Secretary shall publish in the Federal Register a notice specifying the DSH allotment to each State under 1923(f) of the Social Security Act for the respective fiscal year specified in such subparagraph, consistent with the application of the DSH Health Reform methodology described in paragraph (2).

(B) PUBLICATAION DEADLINE.—The publication deadline specified in this subparagraph is—

(i) January 1, 2016, with respect to DSH allotments described in subparagraph (A) for fiscal year 2017;

(ii) January 1, 2017, with respect to DSH allotments described in subparagraph (A) for fiscal year 2018; and

(iii) January 1, 2018, with respect to DSH allotments described in subparagraph (A) for fiscal year 2019.

(c) CONFORMING AMENDMENTS.—

(1) Section 1923(f) of the Social Security Act (42 U.S.C. 1396r–4(f)) is amended—

(A) by redesignating paragraph (7) as paragraph (8); and

(B) by inserting after paragraph (6) the following new paragraph:

"(7) SPECIAL RULE FOR FISCAL YEARS 2017, 2018, AND 2019.—

"(A) FISCAL YEAR 2017.—Notwithstanding paragraph (2), the total DSH allotments for all States for—

"(i) fiscal year 2017, shall be the total DSH allotments that would otherwise be determined under this subsection for such fiscal year decreased by $1,500,000,000;

"(ii) fiscal year 2018, shall be the total DSH allotments that would otherwise be determined under this subsection for

such fiscal year decreased by $2,500,000,000; and

''(iii) fiscal year 2019, shall be the total DSH allotments that would otherwise be determined under this subsection for such fiscal year decreased by $6,000,000,000.''.

(2) Section 1923(b)(4) of such Act (42 U.S.C. 1396r–4(b)(4)) is amended by adding before the period the following: ''or to affect the authority of the Secretary to issue and implement the DSH Health Reform methodology under section 1704(b)(2) of the America's Health Choices Act of 2009''.

(d) DISPROPORTIONATE SHARE HOSPITALS (DSH) AND ESSENTIAL ACCESS HOSPITAL (EAH) NON-DISCRIMINATION.—

(1) IN GENERAL.—Section 1923(d) of the Social Security Act (42 U.S.C. 1396r-4) is amended by adding at the end the following new paragraph:

''(4) No hospital may be defined or deemed as a disproportionate share hospital, or as an essential access hospital (for purposes of subsection (f)(6)(A)(iv), under a State plan under this title or subsection (b) of this section (including any waiver under section 1115) unless the hospital—

''(A) provides services to beneficiaries under this title without discrimination on the ground of race, color, national origin, creed, source of payment, status as a beneficiary under this title, or any other ground unrelated to such beneficiary's need for the services or the availability of the needed services in the hospital; and

''(B) makes arrangements for, and accepts, reimbursement under this title for services provided to eligible beneficiaries under this title.''.

(2) EFFECTIVE DATE.—The amendment made by subsection (a) shall be apply to expenditures made on or after July 1, 2010.

SEC. 1705. EXPANDED OUTSTATIONING.

(a) IN GENERAL.—Section 1902(a)(55) of the Social Security Act (42 U.S.C. 1396a(a)(55)) is amended by striking ''under subsection (a)(10)(A)(i)(IV), (a)(10)(A)(i)(VI), (a)(10)(A)(i)(VII), or (a)(10)(A)(ii)(IX)'' and inserting ''(including receipt and processing of applications of individuals for affordability credits under subtitle C of title II of division A of the America's Affordable Health Choices Act of 2009 pursuant to a Medicaid memorandum of understanding under section 1943(a)(1))''.

(b) EFFECTIVE DATE.—

(1) Except as provided in paragraph (2), the amendment made by subsection (a) shall apply to services furnished on or after July 1, 2010, without regard to whether or not final regulations to carry out such amendment have been promulgated by such date.

(2) In the case of a State plan for medical assistance under title XIX of the Social Security Act which the Secretary of Health and Human Services determines requires State legislation (other than legislation appropriating funds) in order for the plan to meet the additional requirement imposed by the amendment made by this section, the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet this additional requirement before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

Subtitle B—Prevention

SEC. 1711. REQUIRED COVERAGE OF PREVENTIVE SERVICES.

(a) COVERAGE.—Section 1905 of the Social Security Act (42 U.S.C. 1396d), as amended by section 1701(a)(2)(B), is amended—

(1) in subsection (a)(4)—

(A) by striking ''and'' before ''(C)''; and

(B) by inserting before the semicolon at the end the following: ''and (D) preventive services described in subsection (z)''; and

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

''(z) PREVENTIVE SERVICES.—The preventive services described in this subsection are services not otherwise described in subsection (a) or (r) that the Secretary determines are—

''(1)(A) recommended with a grade of A or B by the Task Force for Clinical Preventive Services; or

''(B) vaccines recommended for use as appropriate by the Director of the Centers for Disease Control and Prevention; and

''(2) appropriate for individuals entitled to medical assistance under this title.''.

(b) CONFORMING AMENDMENT.—Section 1928 of such Act (42 U.S.C. 1396s) is amended—

(1) in subsection (c)(2)(B)(i), by striking ''the advisory committee referred to in subsection (e)'' and inserting ''the Director of the Centers for Disease Control and Prevention'' ;

(2) in subsection (e), by striking ''Advisory Committee'' and all that follows and inserting ''Director of the Centers for Disease Control and Prevention.''; and

(3) by striking subsection (g).

(c) EFFECTIVE DATE.—

(1) Except as provided in paragraph (2), the amendments made by this section shall apply to services furnished on or after July 1, 2010, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.

(2) In the case of a State plan for medical assistance under title XIX of the Social Security Act which the Secretary of Health and Human Services determines requires State legislation (other than legislation appropriating funds) in order for the plan to meet the additional requirements imposed by the amendments made by this section, the State plan

shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet these additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

SEC. 1712. TOBACCO CESSATION.

(a) DROPPING TOBACCO CESSATION EXCLUSION FROM COVERED OUTPATIENT DRUGS.—Section 1927(d)(2) of the Social Security Act (42 U.S.C. 1396r–8(d)(2)) is amended—

(1) by striking subparagraph (E);

(2) in subparagraph (G), by inserting before the period at the end the following: ‘‘, except agents approved by the Food and Drug Administration for purposes of promoting, and when used to promote, tobacco cessation’’; and

(3) by redesignating subparagraphs (F) through (K) as subparagraphs (E) through (J), respectively.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to drugs and services furnished on or after January 1, 2010.

SEC. 1713. OPTIONAL COVERAGE OF NURSE HOME VISITATION SERVICES.

(a) IN GENERAL.—Section 1905 of the Social Security Act (42 U.S.C. 1396d), as amended by sections 1701(a)(2) and 1711(a), is amended—

(1) in subsection (a)—

(A) in paragraph (27), by striking ''and'' at the end;

(B) by redesignating paragraph (28) as paragraph (29); and

(C) by inserting after paragraph (27) the following new paragraph:

''(28) nurse home visitation services (as defined in subsection (aa)); and''; and.

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

''(aa) The term 'nurse home visitation services' means home visits by trained nurses to families with a first-time pregnant woman, or a child (under 2 years of age), who is eligible for medical assistance under this title, but only, to the extent determined by the Secretary based

upon evidence, that such services are effective in one or more of the following:

''(1) Improving maternal or child health and pregnancy outcomes or increasing birth intervals between pregnancies.

''(2) Reducing the incidence of child abuse, neglect, and injury, improving family stability (including reduction in the incidence of intimate partner violence), or reducing maternal and child involvement in the criminal justice system.

''(3) Increasing economic self-sufficiency, employment advancement, school-readiness, and educational achievement, or reducing dependence on public assistance.''.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after January 1, 2010.

(c) CONSTRUCTION.—Nothing in the amendments made by this section shall be construed as affecting the ability of a State under title XIX or XXI of the Social Security Act to provide nurse home visitation services as part of another class of items and services falling within the definition of medical assistance or child health assistance under the respective title, or as an administrative expenditure for which payment is made under section

1903(a) or 2105(a) of such Act, respectively, on or after the date of the enactment of this Act.

SEC. 1714. STATE ELIGIBILITY OPTION FOR FAMILY PLANNING SERVICES.

(a) COVERAGE AS OPTIONAL CATEGORICALLY NEEDY GROUP.—

(1) IN GENERAL.—Section 1902(a)(10)(A)(ii) of the Social Security Act (42 U.S.C. 1396a(a)(10)(A)(ii)) is amended—

(A) in subclause (XVIII), by striking ''or'' at the end;

(B) in subclause (XIX), by adding ''or'' at the end; and

(C) by adding at the end the following new subclause:

''(XX) who are described in subsection (hh) (relating to individuals who meet certain income standards);''.

(2) GROUP DESCRIBED.—Section 1902 of such Act (42 U.S.C. 1396a), as amended by section 1703, is amended by adding at the end the following new subsection:

''(hh)(1) Individuals described in this subsection are individuals—

''(A) whose income does not exceed an income eligibility level established by the State that does not exceed the highest income eligibility level established under the State plan under this title (or under its State child health plan under title XXI) for pregnant women; and

''(B) who are not pregnant.

''(2) At the option of a State, individuals described in this subsection may include individuals who, had individuals applied on or before January 1, 2007, would have been made eligible pursuant to the standards and processes imposed by that State for benefits described in clause (XV) of the matter following subparagraph (G) of section subsection (a)(10) pursuant to a waiver granted under section 1115.

''(3) At the option of a State, for purposes of subsection (a)(17)(B), in determining eligibility for services under this subsection, the State may consider only the income of the applicant or recipient.''.

(3) LIMITATION ON BENEFITS.—Section 1902(a)(10) of such Act (42 U.S.C. 1396a(a)(10)) is amended in the matter following subparagraph (G)—

(A) by striking ''and (XIV)'' and inserting ''(XIV)''; and

(B) by inserting '', and (XV) the medical assistance made available to an individual described in subsection (hh) shall be limited to family planning services and supplies described in section 1905(a)(4)(C) including medical diagnosis and treatment services that are provided pursuant to a family planning service in a family planning setting'' after ''cervical cancer''.

(4) CONFORMING AMENDMENTS.—Section 1905(a) of such Act (42 U.S.C. 1396d(a)), as amended by section 1731(c), is amended in the matter preceding paragraph (1)—

(A) in clause (xiii), by striking ''or'' at the end;

(B) in clause (xiv), by adding ''or'' at the end; and

(C) by inserting after clause (xiv) the following:

''(xv) individuals described in section 1902(hh),''.

(b) PRESUMPTIVE ELIGIBILITY.—

(1) IN GENERAL.—Title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) is amended by inserting after section 1920B the following:

''PRESUMPTIVE ELIGIBILITY FOR FAMILY PLANNING SERVICES

''SEC. 1920C. (a) STATE OPTION.—State plan approved under section 1902 may provide for making medical assistance available to an individual described in section 1902(hh) (relating to individuals who meet certain income eligibility standard) during a presumptive eligibility period. In the case of an individual described in section 1902(hh), such medical assistance shall be limited to family planning services and supplies described in 1905(a)(4)(C) and, at the State's option, medical diagnosis and treatment services that are provided in conjunction with a family planning service in a family planning setting.

''(b) DEFINITIONS.—For purposes of this section:

''(1) PRESUMPTIVE ELIGIBILITY PERIOD.—The term 'presumptive eligibility period' means, with respect to an individual described in subsection (a), the period that—

''(A) begins with the date on which a qualified entity determines, on the basis of preliminary information, that the individual is described in section 1902(hh); and

''(B) ends with (and includes) the earlier of—

''(i) the day on which a determination is made with respect to the eligibility of such individual for services under the State plan; or

''(ii) in the case of such an individual who does not file an application by the last day of the month following the month during which the entity makes the determination referred to in subparagraph (A), such last day.

''(2) QUALIFIED ENTITY.—

''(A) IN GENERAL.—Subject to subparagraph (B), the term 'qualified entity' means any entity that—

''(i) is eligible for payments under a State plan approved under this title; and

''(ii) is determined by the State agency to be capable of making determinations of the type described in paragraph (1)(A).

''(B) RULE OF CONSTRUCTION.—Nothing in this paragraph shall be construed as preventing a State from limiting the classes of en-

tities that may become qualified entities in order to prevent fraud and abuse.

''(c) ADMINISTRATION.—

''(1) IN GENERAL.—The State agency shall provide qualified entities with—

''(A) such forms as are necessary for an application to be made by an individual described in subsection (a) for medical assistance under the State plan; and

''(B) information on how to assist such individuals in completing and filing such forms.

''(2) NOTIFICATION REQUIREMENTS.—A qualified entity that determines under subsection (b)(1)(A) that an individual described in subsection (a) is presumptively eligible for medical assistance under a State plan shall—

''(A) notify the State agency of the determination within 5 working days after the date on which determination is made; and

''(B) inform such individual at the time the determination is made that an application for medical assistance is required to be made by not later than the last day of the month following the month during which the determination is made.

''(3) APPLICATION FOR MEDICAL ASSISTANCE.—In the case of an individual described in subsection (a) who is determined by a qualified entity to be presumptively eligible for medical assistance under a State plan, the individual shall apply for medical assistance by not later than the last day of the month following the month during which the determination is made.

''(d) PAYMENT.—Notwithstanding any other provision of law, medical assistance that—

''(1) is furnished to an individual described in subsection (a)—

''(A) during a presumptive eligibility period;

''(B) by a entity that is eligible for payments under the State plan; and

''(2) is included in the care and services covered by the State plan,

shall be treated as medical assistance provided by such plan for purposes of clause (4) of the first sentence of section 1905(b).''.

(2) CONFORMING AMENDMENTS.—

(A) Section 1902(a)(47) of the Social Security Act (42 U.S.C. 1396a(a)(47)) is amended by inserting before the semicolon at the end

the following: ''and provide for making medical assistance available to individuals described in subsection (a) of section 1920C during a presumptive eligibility period in accordance with such section''.

(B) Section 1903(u)(1)(D)(v) of such Act (42 U.S.C. 1396b(u)(1)(D)(v)) is amended—

(i) by striking ''or for'' and inserting ''for''; and

(ii) by inserting before the period the following: '', or for medical assistance provided to an individual described in subsection (a) of section 1920C during a presumptive eligibility period under such section''.

(c) CLARIFICATION OF COVERAGE OF FAMILY PLANNING SERVICES AND SUPPLIES.—Section 1937(b) of the Social Security Act (42 U.S.C. 1396u–7(b)) is amended by adding at the end the following:

''(5) COVERAGE OF FAMILY PLANNING SERVICES AND SUPPLIES.—Notwithstanding the previous provisions of this section, a State may not provide for medical assistance through enrollment of an individual with benchmark coverage or benchmark-equivalent coverage under this section unless such cov-

erage includes for any individual described in section 1905(a)(4)(C), medical assistance for family planning services and supplies in accordance with such section.''.

(d) EFFECTIVE DATE.—The amendments made by this section take effect on the date of the enactment of this Act and shall apply to items and services furnished on or after such date.

Subtitle C—Access

SEC. 1721. PAYMENTS TO PRIMARY CARE PRACTITIONERS.

(a) IN GENERAL.—

(1) FEE-FOR-SERVICE PAYMENTS.—Section 1902(a)(13) of the Social Security Act (42 U.S.C. 1396b(a)(13)) is amended—

(A) by striking ''and'' at the end of subparagraph (A);

(B) by adding ''and'' at the end of subparagraph (B); and

(C) by adding at the end the following new subparagraph:

''(C) payment for primary care services (as defined in section 1848(j)(5)(A), but applied without regard to clause (ii) thereof) furnished by physicians (or for services furnished by other health care professionals that would be primary

care services under such section if furnished by a physician) at a rate not less than 80 percent of the payment rate applicable to such services and physicians or professionals (as the case may be) under part B of title XVIII for services furnished in 2010, 90 percent of such rate for services and physicians (or professionals) furnished in 2011, and 100 percent of such payment rate for services and physicians (or professionals) furnished in 2012 or a subsequent year;''.

(2) UNDER MEDICAID MANAGED CARE PLANS.—Section 1923(f) of such Act (42 U.S.C. 1396u–2(f)) is amended—

(A) in the heading, by adding at the end the following: ''; ADEQUACY OF PAYMENT FOR PRIMARY CARE SERVICES''; and

(B) by inserting before the period at the end the following: ''and, in the case of primary care services described in section 1902(a)(13)(C), consistent with the minimum payment rates specified in such section (regardless of the manner in which such payments are made, including in the form of capitation or partial capitation)''.

(b) INCREASE IN PAYMENT USING 100% FMAP.—Section 1905(y), as added by section 1701(a)(2)(B) and as amended by section 1701(c)(2), is amended by adding at the end the following:

''(3)(A) The portion of the amounts expended for medical assistance for services described in section 1902(a)(13)(C) furnished on or after January 1, 2010, that is attributable to the amount by which the minimum payment rate required under such section (or, by application, section 1932(f)) exceeds the payment rate applicable to such services under the State plan as of June 16, 2009.

''(B) Subparagraphs (A) shall not be construed as preventing the payment of Federal financial participation based on the Federal medical assistance percentage for amounts in excess of those specified under such subparagraphs.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after January 1, 2010.

SEC. 1722. MEDICAL HOME PILOT PROGRAM.

(a) IN GENERAL.—The Secretary of Health and Human Services shall establish under this section a medical home pilot program under which a State may apply to the Secretary for approval of a medical home pilot

project described in subsection (b) (in this section referred to as a ''pilot project'') for the application of the medical home concept under title XIX of the Social Security Act. The pilot program shall operate for a period of up to 5 years.

(b) PILOT PROJECT DESCRIBED.—

(1) IN GENERAL.—A pilot project is a project that applies one or more of the medical home models described in section 1866E(a)(3) of the Social Security Act (as inserted by section 1302(a)) or such other model as the Secretary may approve, to high need beneficiaries (including medically fragile children and high-risk pregnant women) who are eligible for medical assistance under title XIX of the Social Security Act. The Secretary shall provide for appropriate coordination of the pilot program under this section with the medical home pilot program under section 1866E of such Act.

(2) LIMITATION.—A pilot project shall be for a duration of not more than 5 years.

(c) ADDITIONAL INCENTIVES.—In the case of a pilot project, the Secretary may—

(1) waive the requirements of section 1902(a)(1) of the Social Security Act (relating to

statewideness) and section 1902(a)(10)(B) of such Act (relating to comparability); and

(2) increase to up to 90 percent (for the first 2 years of the pilot program) or 75 percent (for the next 3 years) the matching percentage for administrative expenditures (such as those for community care workers).

(d) MEDICALLY FRAGILE CHILDREN.—In the case of a model involving medically fragile children, the model shall ensure that the patient-centered medical home services received by each child, in addition to fulfilling the requirements under 1866E(b)(1) of the Social Security Act, provide for continuous involvement and education of the parent or caregiver and for assistance to the child in obtaining necessary transitional care if a child's enrollment ceases for any reason.

(e) EVALUATION; REPORT.—

(1) EVALUATION.—The Secretary, using the criteria described in section 1866E(g)(1) of the Social Security Act (as inserted by section 1123), shall conduct an evaluation of the pilot program under this section.

(2) REPORT.—Not later than 60 days after the date of completion of the evaluation under paragraph (1), the Secretary shall submit to Congress

and make available to the public a report on the findings of the evaluation under such paragraph.

(f) FUNDING.—The additional Federal financial participation resulting from the implementation of the pilot program under this section may not exceed in the aggregate $1,235,000,000 over the 5-year period of the program.

SEC. 1723. TRANSLATION OR INTERPRETATION SERVICES.

(a) IN GENERAL.—Section 1903(a)(2)(E) of the Social Security Act (42 U.S.C. 1396b(a)(2)), as added by section 201(b)(2)(A) of the Children's Health Insurance Program Reauthorization Act of 2009 (Public Law 111–3), is amended by inserting ''and other individuals'' after ''children of families''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to payment for translation or interpretation services furnished on or after January 1, 2010.

SEC. 1724. OPTIONAL COVERAGE FOR FREESTANDING BIRTH CENTER SERVICES.

(a) IN GENERAL.—Section 1905 of the Social Security Act (42 U.S.C. 1396d), as amended by section 1713(a), is amended—

(1) in subsection (a)—

(A) by redesignating paragraph (29) as paragraph (30);

(B) in paragraph (28), by striking at the end ''and''; and

(C) by inserting after paragraph (28) the following new paragraph:

''(29) freestanding birth center services (as defined in subsection (l)(3)(A)) and other ambulatory services that are offered by a freestanding birth center (as defined in subsection (l)(3)(B)) and that are otherwise included in the plan; and''; and

(2) in subsection (l), by adding at the end the following new paragraph:

''(3)(A) The term 'freestanding birth center services' means services furnished to an individual at a freestanding birth center (as defined in subparagraph (B)), including by a licensed birth attendant (as defined in subparagraph (C)) at such center.

''(B) The term 'freestanding birth center' means a health facility—

''(i) that is not a hospital; and

''(ii) where childbirth is planned to occur away from the pregnant woman's residence.

''(C) The term 'licensed birth attendant' means an individual who is licensed or registered by the State in-

volved to provide health care at childbirth and who provides such care within the scope of practice under which the individual is legally authorized to perform such care under State law (or the State regulatory mechanism provided by State law), regardless of whether the individual is under the supervision of, or associated with, a physician or other health care provider. Nothing in this subparagraph shall be construed as changing State law requirements applicable to a licensed birth attendant.''.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to items and services furnished on or after the date of the enactment of this Act.

SEC. 1725. INCLUSION OF PUBLIC HEALTH CLINICS UNDER THE VACCINES FOR CHILDREN PROGRAM.

Section 1928(b)(2)(A)(iii)(I) of the Social Security Act (42 U.S.C. 1396s(b)(2)(A)(iii)(I)) is amended—

(1) by striking ''or a rural health clinic'' and inserting '', a rural health clinic''; and

(2) by inserting ''or a public health clinic,'' after '''1905(l)(1)),''.

Subtitle D—Coverage

SEC. 1731. OPTIONAL MEDICAID COVERAGE OF LOW-INCOME HIV-INFECTED INDIVIDUALS.

(a) IN GENERAL.— Section 1902 of the Social Security Act (42 U.S.C. 1396a), as amended by section 1714(a)(1), is amended—

(1) in subsection (a)(10)(A)(ii)—

(A) by striking ''or'' at the end of subclause (XIX);

(B) by adding ''or'' at the end of subclause (XX); and

(C) by adding at the end the following:

''(XXI) who are described in subsection (ii) (relating to HIV-infected individuals);''; and

(2) by adding at the end, as amended by sections 1703 and 1714(a), the following:

''(ii) individuals described in this subsection are individuals not described in subsection (a)(10)(A)(i)—

''(1) who have HIV infection;

''(2) whose income (as determined under the State plan under this title with respect to disabled individuals) does not exceed the maximum amount of income a disabled individual described in subsection (a)(10)(A)(i) may have and obtain medical assistance under the plan; and

''(3) whose resources (as determined under the State plan under this title with respect to disabled individuals) do not exceed the maximum amount of resources a disabled individual described in subsection (a)(10)(A)(i) may have and obtain medical assistance under the plan.''.

(b) ENHANCED MATCH.—The first sentence of section 1905(b) of such Act (42 U.S.C. 1396d(b)) is amended by striking ''section 1902(a)(10)(A)(ii)(XVIII)'' and inserting ''subclause (XVIII) or (XX) of section 1902(a)(10)(A)(ii)''.

(c) CONFORMING AMENDMENTS.—Section 1905(a) of such Act (42 U.S.C. 1396d(a)) is amended, in the matter preceding paragraph (1)—

(1) by striking ''or'' at the end of clause (xii);

(2) by adding ''or'' at the end of clause (xiii); and

(3) by inserting after clause (xiii) the following:

''(xiv) individuals described in section 1902(ii),''.

(d) EXEMPTION FROM FUNDING LIMITATION FOR TERRITORIES.—Section 1108(g) of the Social Security Act (42 U.S.C. 1308(g)) is amended by adding at the end the following:

''(5) DISREGARDING MEDICAL ASSISTANCE FOR OPTIONAL LOW-INCOME HIV-INFECTED INDIVIDUALS.—The limitations under subsection (f) and the previous provisions of this subsection shall not apply to amounts expended for medical assistance for individuals described in section 1902(ii) who are only eligible for such assistance on the basis of section 1902(a)(10)(A)(ii)(XX).''.

(e) EFFECTIVE DATE; SUNSET.—The amendments made by this section shall apply to expenditures for calendar quarters beginning on or after the date of the enactment of this Act, and before January 1, 2013, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.

SEC. 1732. EXTENDING TRANSITIONAL MEDICAID ASSISTANCE (TMA).

Sections 1902(e)(1)(B) and 1925(f) of the Social Security Act (42 U.S.C. 1396a(e)(1)(B), 1396r–6(f)), as amended by section 5004(a)(1) of the American Recovery and Reinvestment Act of 2009 (Public Law 111–5), are each amended by striking ''December 31, 2010'' and inserting ''December 31, 2012''.

SEC. 1733. REQUIREMENT OF 12-MONTH CONTINUOUS COVERAGE UNDER CERTAIN CHIP PROGRAMS.

(a) IN GENERAL.—Section 2102(b) of the Social Security Act (42 U.S.C. 1397bb(b)) is amended by adding at the end the following new paragraph:

''(6) REQUIREMENT FOR 12-MONTH CONTINUOUS ELIGIBILITY.—In the case of a State child health plan that provides child health assistance under this title through a means other than described in section 2101(a)(2), the plan shall provide for implementation under this title of the 12-month continuous eligibility option described in section 1902(e)(12) for targeted low-income children whose family income is below 200 percent of the poverty line.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to determinations (and redeterminations) of eligibility made on or after January 1, 2010.

Subtitle E—Financing

SEC. 1741. PAYMENTS TO PHARMACISTS.

(a) PHARMACY REIMBURSEMENT LIMITS.—

(1) IN GENERAL.—Section 1927(e) of the Social Security Act (42 U.S.C. 1396r–8(e)) is amended—

(A) by striking paragraph (5) and inserting the following:

''(5) USE OF AMP IN UPPER PAYMENT LIMITS.—The Secretary shall calculate the Federal upper reimbursement limit established under paragraph (4) as 130 percent of the weighted average (determined on the basis of manufacturer utilization) of monthly average manufacturer prices.''

(2) DEFINITION OF AMP.—Section 1927(k)(1)(B) of such Act (42 U.S.C. 1396r–8(k)(1)(B)) is amended—

(B) in the heading, by striking ''EXTENDED TO WHOLESALERS'' and inserting ''AND OTHER PAYMENTS''; and

(C) by striking ''regard to'' and all that follows through the period and inserting the following: ''regard to—

''(i) customary prompt pay discounts extended to wholesalers;

''(ii) bona fide service fees paid by manufacturers;

''(iii) reimbursement by manufacturers for recalled, damaged, expired, or otherwise unsalable returned goods, including reimbursement for the cost of the goods and any reimbursement of costs associated

with return goods handling and processing, reverse logistics, and drug destruction;

''(iv) sales directly to, or rebates, discounts, or other price concessions provided to, pharmacy benefit managers, managed care organizations, health maintenance organizations, insurers, mail order pharmacies that are not open to all members of the public, or long term care providers, provided that these rebates, discounts, or price concessions are not passed through to retail pharmacies;

''(v) sales directly to, or rebates, discounts, or other price concessions provided to, hospitals, clinics, and physicians, unless the drug is an inhalation, infusion, or injectable drug, or unless the Secretary determines, as allowed for in Agency administrative procedures, that it is necessary to include such sales, rebates, discounts, and price concessions in order to obtain an accurate AMP for the drug. Such a determination shall not be subject to judicial review; or

''(vi) rebates, discounts, and other price concessions required to be provided under agreements under subsections (f) and (g) of section 1860D–2(f).''.

(3) MANUFACTURER REPORTING REQUIREMENTS.—Section 1927(b)(3) of such Act (42 U.S.C. 1396r–8(b)(3)) is amended—

(A) in subparagraph (A), by adding at the end the following new clause:

''(iv) not later than 30 days after the last day of each month of a rebate period under the agreement, on the manufacturer's total number of units that are used to calculate the monthly average manufacturer price for each covered outpatient drug.''

(4) AUTHORITY TO PROMULGATE REGULATION.—The Secretary of Health and Human Services may promulgate regulations to clarify the requirements for upper payment limits and for the determination of the average manufacturer price in an expedited manner. Such regulations may become effective on an interim final basis, pending opportunity for public comment.

(5) PHARMACY REIMBURSEMENTS THROUGH DECEMBER 31, 2010.—The specific upper limit under section 447.332 of title 42, Code of Federal Regulations (as in effect on December 31, 2006) applicable to payments made by a State for multiple source drugs under a State Medicaid plan shall continue to apply through December 31, 2010, for purposes of the availability of Federal financial participation for such payments.

(b) DISCLOSURE OF PRICE INFORMATION TO THE PUBLIC.—Section 1927(b)(3) of such Act (42 U.S.C. 1396r–8(b)(3)) is amended—

(1) in subparagraph (A)—

(A) in clause (i), in the matter preceding subclause (I), by inserting ''month of a'' after ''each''; and

(B) in the last sentence, by striking ''and shall,'' and all that follows through the period; and

(2) in subparagraph (D)(v), by inserting ''weighted'' before ''average manufacturer prices''.

SEC. 1742. PRESCRIPTION DRUG REBATES.

(a) ADDITIONAL REBATE FOR NEW FORMULATIONS OF EXISTING DRUGS.—

(1) IN GENERAL.—Section 1927(c)(2) of the Social Security Act (42 U.S.C. 1396r–8(c)(2)) is amended by adding at the end the following new subparagraph:

''(C) TREATMENT OF NEW FORMULATIONS.—In the case of a drug that is a line extension of a single source drug or an innovator multiple source drug that is an oral solid dosage form, the rebate obligation with respect to such drug under this section shall be the amount computed under this section for such new drug or, if greater, the product of—

''(i) the average manufacturer price of the line extension of a single source drug or an innovator multiple source drug that is an oral solid dosage form;

''(ii) the highest additional rebate (calculated as a percentage of average manufacturer price) under this section for any strength of the original single source drug or innovator multiple source drug; and

''(iii) the total number of units of each dosage form and strength of the line extension product paid for under the State

plan in the rebate period (as reported by the State).

In this subparagraph, the term 'line extension' means, with respect to a drug, an extended release formulation of the drug.''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to drugs dispensed after December 31, 2009.

(b) INCREASE MINIMUM REBATE PERCENTAGE FOR SINGLE SOURCE DRUGS.—Section 1927(c)(1)(B)(i) of the Social Security Act (42 U.S.C. 1396r–8(c)(1)(B)(i)) is amended—

(1) in subclause (IV), by striking ''and'' at the end;

(2) in subclause (V)—

(A) by inserting ''and before January 1, 2010'' after ''December 31, 1995,''; and

(B) by striking the period at the end and inserting ''; and''; and

(3) by adding at the end the following new subclause:

''(VI) after December 31, 2009, is 22.1 percent.''.

SEC. 1743. EXTENSION OF PRESCRIPTION DRUG DISCOUNTS TO ENROLLEES OF MEDICAID MANAGED CARE ORGANIZATIONS.

(a) IN GENERAL.—Section 1903(m)(2)(A) of the Social Security Act (42 U.S.C. 1396b(m)(2)(A)) is amended—

(1) in clause (xi), by striking ''and'' at the end;

(2) in clause (xii), by striking the period at the end and inserting ''; and''; and

(3) by adding at the end the following:

''(xiii) such contract provides that the entity shall report to the State such information, on such timely and periodic basis as specified by the Secretary, as the State may require in order to include, in the information submitted by the State to a manufacturer under section 1927(b)(2)(A), information on covered outpatient drugs dispensed to individuals eligible for medical assistance who are enrolled with the entity and for which the entity is responsible for coverage of such drugs under this subsection.''.

(b) CONFORMING AMENDMENTS.—Section 1927 of such Act (42 U.S.C. 1396r-8) is amended——

(1) in the first sentence of subsection (b)(1)(A), by inserting before the period at the end the following: '', including such drugs dispensed to individuals enrolled with a medicaid managed care organi-

zation if the organization is responsible for coverage of such drugs'';

(2) in subsection (b)(2), by adding at the end the following new subparagraph:

''(C) REPORTING ON MMCO DRUGS.—On a quarterly basis, each State shall report to the Secretary the total amount of rebates in dollars received from pharmacy manufacturers for drugs provided to individuals enrolled with Medicaid managed care organizations that contract under section 1903(m).''; and

(3) in subsection (j)—

(A) in the heading by striking ''EXEMPTION'' and inserting ''SPECIAL RULES''; and

(B) in paragraph (1), by striking ''not''.

(c) EFFECTIVE DATE.—The amendments made by this section take effect on July 1, 2010, and shall apply to drugs dispensed on or after such date, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.

SEC. 1744. PAYMENTS FOR GRADUATE MEDICAL EDUCATION.

(a) IN GENERAL.—Section 1905 of the Social Security Act (42 U.S.C. 1396d), as amended by sections

1701(a)(2), 1711(a), and 1713(a), is amended by adding at the end the following new subsection:

"(bb) PAYMENT FOR GRADUATE MEDICAL EDUCATION.—

"(1) IN GENERAL.—The term 'medical assistance' includes payment for costs of graduate medical education consistent with this subsection, whether provided in or outside of a hospital.

"(2) SUBMISSION OF INFORMATION.—For purposes of paragraph (1) and section 1902(a)(13)(A)(v), payment for such costs is not consistent with this subsection unless—

"(A) the State submits to the Secretary, in a timely manner and on an annual basis specified by the Secretary, information on total payments for graduate medical education and how such payments are being used for graduate medical education, including—

"(i) the institutions and programs eligible for receiving the funding;

"(ii) the manner in which such payments are calculated;

"(iii) the types and fields of education being supported;

''(iv) the workforce or other goals to which the funding is being applied;

''(v) State progress in meeting such goals; and

''(vi) such other information as the Secretary determines will assist in carrying out paragraphs (3) and (4); and

''(B) such expenditures are made consistent with such goals and requirements as are established under paragraph (4).

''(3) REVIEW OF INFORMATION.—The Secretary shall make the information submitted under paragraph (2) available to the Advisory Committee on Health Workforce Evaluation and Assessment (established under section 2261 of the Public Health Service Act). The Secretary and the Advisory Committee shall independently review the information submitted under paragraph (2), taking into account State and local workforce needs.

''(4) SPECIFICATION OF GOALS AND REQUIREMENTS.—The Secretary shall specify by rule, initially published by not later than December 31, 2011—

''(A) program goals for the use of funds described in paragraph (1), taking into account

recommendations of the such Advisory Committee and the goals for approved medical residency training programs described in section 1886(h)(1)(B); and

''(B) requirements for use of such funds consistent with such goals.

Such rule may be effective on an interim basis pending revision after an opportunity for public comment.''.

(b) CONFORMING AMENDMENT.—Section 1902(a)(13)(A) of such Act (42 U.S.C. 1396a(a)(13)(A)) is amended—

(1) by striking ''and'' at the end of clause (iii);

(2) by striking ''; and'' and inserting '', and'';

and

(3) by adding at the end the following new clause:

''(v) in the case of hospitals and at the option of a State, such rates may include, to the extent consistent with section 1905(bb), payment for graduate medical education; and''.

(c) EFFECTIVE DATE.—The amendments made by this section shall take effect on the date of the enactment of this Act. Nothing in this section shall be construed as

affecting payments made before such date under a State plan under title XIX of the Social Security Act for graduate medical education.

Subtitle F—Waste, Fraud, and Abuse

SEC. 1751. HEALTH-CARE ACQUIRED CONDITIONS.

(a) MEDICAID NON-PAYMENT FOR CERTAIN HEALTH CARE-ACQUIRED CONDITIONS.—Section 1903(i) of the Social Security Act (42 U.S.C. 1396b(i)) is amended—

(1) by striking ''or'' at the end of paragraph (23);

(2) by striking the period at the end of paragraph (24) and inserting ''; or''; and

(3) by inserting after paragraph (24) the following new paragraph:

''(25) with respect to amounts expended for services related to the presence of a condition that could be identified by a secondary diagnostic code described in section 1886(d)(4)(D)(iv) and for any health care acquired condition determined as a non-covered service under title XVIII.''.

(b) APPLICATION TO CHIP.—Section 2107(e)(1)(G) of such Act (42 U.S.C. 1397gg(e)(1)(G)) is amended by striking ''and (17)'' and inserting ''(17), and (25)''.

(c) PERMISSION TO INCLUDE ADDITIONAL HEALTH CARE-ACQUIRED CONDITIONS.—Nothing in this section shall prevent a State from including additional health care-acquired conditions for non-payment in its Medicaid program under title XIX of the Social Security Act.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to discharges occurring on or after January 1, 2010.

SEC. 1752. EVALUATIONS AND REPORTS REQUIRED UNDER MEDICAID INTEGRITY PROGRAM.

Section 1936(c)(2)) of the Social Security Act (42 U.S.C. 1396u–7(c)(2)) is amended—

(1) by redesignating subparagraph (D) as subparagraph (E); and

(2) by inserting after subparagraph (C) the following new subparagraph:

''(D) For the contract year beginning in 2011 and each subsequent contract year, the entity provides assurances to the satisfaction of the Secretary that the entity will conduct periodic evaluations of the effectiveness of the activities carried out by such entity under the Program and will submit to the Secretary an annual report on such activities.''.

SEC. 1753. REQUIRE PROVIDERS AND SUPPLIERS TO ADOPT PROGRAMS TO REDUCE WASTE, FRAUD, AND ABUSE.

Section 1902(a) of such Act (42 U.S.C. 42 U.S.C. 1396a(a)), as amended by sections 1631(b)(1) and 1703, is further amended—

(1) in paragraph (74), by striking at the end ''and'';

(2) in paragraph (75), by striking at the end the period and inserting ''; and''; and

(3) by inserting after paragraph (75) the following new paragraph:

''(76) provide that any provider or supplier (other than a physician or nursing facility) providing services under such plan shall, subject to paragraph (5) of section 1874(d), establish a compliance program described in paragraph (1) of such section in accordance with such section.''.

SEC. 1754. OVERPAYMENTS.

(a) IN GENERAL.—Section 1903(d)(2)(C) of the Social Security Act (42 U.S.C. 1396b(d)(2)(C)) is amended by inserting ''(or 1 year in the case of overpayments due to fraud)'' after ''60 days''.

(b) EFFECTIVE DATE.—In the case overpayments discovered on or after the date of the enactment of this Act.

SEC. 1755. MANAGED CARE ORGANIZATIONS.

(a) MINIMUM MEDICAL LOSS RATIO.—

(1) MEDICAID.—Section 1903(m)(2)(A) of the Social Security Act (42 U.S.C. 1396b(m)(2)(A)), as amended by section 1743(a)(3), is amended—

(A) by striking ''and'' at the end of clause (xii);

(B) by striking the period at the end of clause (xiii) and inserting ''; and''; and

(C) by adding at the end the following new clause:

''(xiv) such contract has a medical loss ratio, as determined in accordance with a methodology specified by the Secretary that is a percentage (not less than 85 percent) as specified by the Secretary.''.

(2) CHIP.—Section 2107(e)(1) of such Act (42 U.S.C. 1397gg(e)(1)) is amended—

(A) by redesignating subparagraphs (H) through (L) as subparagraphs (I) through (M); and

(B) by inserting after subparagraph (G) the following new subparagraph:

''(H) Section 1903(m)(2)(A)(xiv) (relating to application of minimum loss ratios), with respect to comparable contracts under this title.''.

(3) EFFECTIVE DATE.—The amendments made by this subsection shall apply to contracts entered into or renewed on or after July 1, 2010.

(b) PATIENT ENCOUNTER DATA.—

(1) IN GENERAL.—Section 1903(m)(2)(A)(xi) of the Social Security Act (42 U.S.C. 1396b(m)(2)(A)(xi)) is amended by inserting ''and for the provision of such data to the State at a frequency and level of detail to be specified by the Secretary'' after ''patients''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply with respect to contract years beginning on or after January 1, 2010.

SEC. 1756. TERMINATION OF PROVIDER PARTICIPATION UNDER MEDICAID AND CHIP IF TERMINATED UNDER MEDICARE OR OTHER STATE PLAN OR CHILD HEALTH PLAN.

(a) STATE PLAN REQUIREMENT.—Section 1902(a)(39) of the Social Security Act (42 U.S.C. 42 U.S.C. 1396a(a)) is amended by inserting after ''1128A,'' the following: ''terminate the participation of any individual or entity in such program if (subject to such exceptions are are permitted with respect to exclusion under sections 1128(b)(3)(C) and 1128(d)(3)(B)) participation of such individual or entity is terminated under title

XVIII, any other State plan under this title, or any child health plan under title XXI,''.

(b) APPLICATION TO CHIP.—Section 2107(e)(1)(A) of such Act (42 U.S.C. 1397gg(e)(1)(A)) is amended by inserting before the period at the end the following: ''and section 1902(a)(39) (relating to exclusion and termination of participation)''.

(c) EFFECTIVE DATE.—

(1) Except as provided in paragraph (2), the amendments made by this section shall apply to services furnished on or after JJanuary 1, 2011, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.

(2) In the case of a State plan for medical assistance under title XIX of the Social Security Act or a child health plan under title XXI of such Act which the Secretary of Health and Human Services determines requires State legislation (other than legislation appropriating funds) in order for the plan to meet the additional requirement imposed by the amendments made by this section, the State plan or child health plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet this additional re-

quirement before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

SEC. 1757. MEDICAID AND CHIP EXCLUSION FROM PARTICIPATION RELATING TO CERTAIN OWNERSHIP, CONTROL, AND MANAGEMENT AFFILIATIONS.

(a) STATE PLAN REQUIREMENT.—Section 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)), as amended by sections 1631(b)(1), 1703, and 1753, is further amended—

(1) in paragraph (75), by striking at the end ''and'';

(2) in paragraph (76), by striking at the end the period and inserting ''; and''; and

(3) by inserting after paragraph (76) the following new paragraph:

''(77) provide that the State agency described in paragraph (9) exclude, with respect to a period, any individual or entity from participation in the program under the State plan if such individual or

entity owns, controls, or manages an entity that (or if such entity is owned, controlled, or managed by an individual or entity that)—

''(A) has unpaid overpayments under this title during such period determined by the Secretary or the State agency to be delinquent;

''(B) is suspended or excluded from participation under or whose participation is terminated under this title during such period; or

''(C) is affiliated with an individual or entity that has been suspended or excluded from participation under this title or whose participation is terminated under this title during such period.''.

(b) CHILD HEALTH PLAN REQUIREMENT.—Section 2107(e)(1)(A) of such Act (42 U.S.C. 1397gg(e)(1)(A)), as amended by section 1756(b), is amended by striking ''section 1902(a)(39)'' and inserting ''sections 1902(a)(39) and 1902(a)(77)''.

(c) EFFECTIVE DATE.—

(1) Except as provided in paragraph (2), the amendments made by this section shall apply to services furnished on or after January 1, 2011, without regard to whether or not final regulations to

carry out such amendments have been promulgated by such date.

(2) In the case of a State plan for medical assistance under title XIX of the Social Security Act or a child health plan under title XXI of such Act which the Secretary of Health and Human Services determines requires State legislation (other than legislation appropriating funds) in order for the plan to meet the additional requirement imposed by the amendments made by this section, the State plan or child health plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet this additional requirement before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

SEC. 1758. REQUIREMENT TO REPORT EXPANDED SET OF DATA ELEMENTS UNDER MMIS TO DETECT FRAUD AND ABUSE.

Section 1903(r)(1)(F) of the Social Security Act (42 U.S.C. 1396b(r)(1)(F)) is amended by inserting after ''necessary'' the following: ''and including, for data submitted to the Secretary on or after July 1, 2010, data elements from the automated data system that the Secretary determines to be necessary for detection of waste, fraud, and abuse''.

SEC. 1759. BILLING AGENTS, CLEARINGHOUSES, OR OTHER ALTERNATE PAYEES REQUIRED TO REGISTER UNDER MEDICAID.

(a) IN GENERAL.—Section 1902(a) of the Social Security Act (42 U.S.C. 42 U.S.C. 1396a(a)), as amended by sections 1631(b), 1703, 1753, and 1757, is further amended—

(1) in paragraph (76); by striking at the end ''and'';

(2) in paragraph (77), by striking the period at the end and inserting ''and''; and

(3) by inserting after paragraph (77) the following new paragraph:

''(78) provide that any agent, clearinghouse, or other alternate payee that submits claims on behalf of a health care provider must register with the

State and the Secretary in a form and manner specified by the Secretary under section 1866(j)(1)(D).''.

(b) DENIAL OF PAYMENT.—Section 1903(i) of such Act (42 U.S.C. 1396b(i)), as amended by section 1753, is amended—

(1) by striking ''or'' at the end of paragraph (24);

(2) by striking the period at the end of paragraph (25) and inserting ''; or''; and

(3) by inserting after paragraph (25) the following new paragraph:

''(26) with respect to any amount paid to a billing agent, clearinghouse, or other alternate payee that is not registered with the State and the Secretary as required under section 1902(a)(78).''.

(c) EFFECTIVE DATE.—

(1) Except as provided in paragraph (2), the amendments made by this section shall apply to claims submitted on or after January 1, 2012, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.

(2) In the case of a State plan for medical assistance under title XIX of the Social Security Act which the Secretary of Health and Human Services

determines requires State legislation (other than legislation appropriating funds) in order for the plan to meet the additional requirement imposed by the amendments made by this section, the State plan or child health plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet this additional requirement before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

SEC. 1760. DENIAL OF PAYMENTS FOR LITIGATION-RELATED MISCONDUCT.

(a) IN GENERAL.—Section 1903(i) of the Social Security Act (42 U.S.C. 1396b(i)), as previously amended is amended—

(1) by striking ''or'' at the end of paragraph (25);

(2) by striking the period at the end of paragraph (26) and inserting a semicolon; and

(3) by inserting after paragraph (26) the following new paragraphs:

''(27) with respect to any amount expended—

''(A) on litigation in which a court imposes sanctions on the State, its employees, or its counsel for litigation-related misconduct; or

''(B) to reimburse (or otherwise compensate) a managed care entity for payment of legal expenses associated with any action in which a court imposes sanctions on the managed care entity for litigation-related misconduct.''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to amounts expended on or after January 1, 2010.

Subtitle G—Puerto Rico and the Territories

SEC. 1771. PUERTO RICO AND TERRITORIES.

(a) INCREASE IN CAP.—

(1) IN GENERAL.—Section 1108(g) of the Social Security Act (42 U.S.C. 1308(g)) is amended—

(A) in paragraph (4) by striking ''and (3)'' and by inserting ''(3), (6), and (7)''; and

(B) by inserting after paragraph (5), as added by section 1731(d), the following new paragraph:

''(6) FISCAL YEARS 2011 THROUGH 2019.—The amounts otherwise determined under this subsection for Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa for fiscal year 2011 and each succeeding fiscal year through fiscal year 2019 shall be increased by the percentage specified under section 1771(c) of the America's Affordable Health Choices Act of 2009 for purposes of this paragraph of the amounts otherwise determined under this section (without regard to this paragraph).

''(7) FISCAL YEAR 2020 AND SUBSEQUENT FISCAL YEARS.—The amounts otherwise determined under this subsection for Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa for fiscal year 2020 and each succeeding fiscal year shall be the amount provided in paragraph (6) or this paragraph for the preceding fiscal year for the respective territory increased by the percentage increase referred to in paragraph (1)(B), rounded to the nearest $10,000 (or $100,000 in the case of Puerto Rico).''.

(2) COORDINATION WITH ARRA.—Section 5001(d) of the American Recovery and Reinvestment Act of 2009 shall not apply during any period for which section 1108(g)(6) of the Social Security Act, as added by paragraph (1), applies.

(b) INCREASE IN FMAP.—

(1) IN GENERAL.—Section 1905(b)(2) of the Social Security Act (42 U.S.C. 1396d(b)(2)) is amended by striking ''50 per centum'' and inserting ''for fiscal years 2011 through 2019, the percentage specified under section 1771(c) of the America's Affordable Health Choices Act of 2009 for purposes of this clause for such fiscal year and for subsequent fiscal years the percentage so specified for fiscal year 2019''.

(2) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to items and services furnished on or after October 1, 2010.

(c) SPECIFICATION OF PERCENTAGES.—The Secretary of Health and Human Services shall specify, before January 1, 2011, the percentages to be applied under section 1108(g)(6) of the Social Security Act, as added by subsection (a)(1), and under section 1905(b)(2) of such Act, as amended by subsection (b)(1), in a manner so that for the period beginning with 2011 and ending with 2019

the total estimated additional Federal expenditures resulting from the application of such percentages will be equal to $10,350,000,000.

Subtitle H—Miscellaneous

SEC. 1781. TECHNICAL CORRECTIONS.

(a) TECHNICAL CORRECTION TO SECTION 1144 OF THE SOCIAL SECURITY ACT.—The first sentence of section 1144(c)(3) of the Social Security Act (42 U.S.C. 1320b—14(c)(3)) is amended—

(1) by striking ''transmittal''; and

(2) by inserting before the period the following: ''as specified in section 1935(a)(4)''.

(b) CLARIFYING AMENDMENT TO SECTION 1935 OF THE SOCIAL SECURITY ACT.—Section 1935(a)(4) of the Social Security Act (42 U.S.C. 1396u—5(a)(4)), as amended by section 113(b) of Public Law 110–275, is amended—

(1) by striking the second sentence;

(2) by redesignating the first sentence as a subparagraph (A) with appropriate indentation and with the following heading: ''IN GENERAL'';

(3) by adding at the end the following subparagraphs:

''(B) FURNISHING MEDICAL ASSISTANCE WITH REASONABLE PROMPTNESS.—For the

purpose of a State's obligation under section 1902(a)(8) to furnish medical assistance with reasonable promptness, the date of the electronic transmission of low-income subsidy program data, as described in section 1144(c), from the Commissioner of Social Security to the State Medicaid Agency, shall constitute the date of filing of such application for benefits under the Medicare Savings Program.

''(C) DETERMINING AVAILABILITY OF MEDICAL ASSISTANCE.—For the purpose of determining when medical assistance will be made available, the State shall consider the date of the individual's application for the low income subsidy program to constitute the date of filing for benefits under the Medicare Savings Program.''.

(c) EFFECTIVE DATE RELATING TO MEDICAID AGENCY CONSIDERATION OF LOW-INCOME SUBSIDY APPLICATION AND DATA TRANSMITTAL.—The amendments made by subsections (a) and (b) shall be effective as if included in the enactment of section 113(b) of Public Law 110–275.

(d) TECHNICAL CORRECTION TO SECTION 605 OF CHIPRA.—Section 605 of the Children's Health Insur-

ance Program Reauthorization Act of 2009 (Public Law 111–3) is amended by striking ''legal residents'' and inserting ''lawfully residing in the United States''.

(e) TECHNICAL CORRECTION TO SECTION 1905 OF THE SOCIAL SECURITY ACT.—Section 1905(a) of the Social Security Act (42 U.S.C. 1396d(a)) is amended by inserting ''or the care and services themselves, or both'' before ''(if provided in or after''.

(f) CLARIFYING AMENDMENT TO SECTION 1115 OF THE SOCIAL SECURITY ACT.—Section 1115(a) of the Social Security Act (42 U.S.C. 1315(a)) is amended by adding at the end the following: ''If an experimental, pilot, or demonstration project that relates to title XIX is approved pursuant to any part of this subsection, such project shall be treated as part of the State plan, all medical assistance provided on behalf of any individuals affected by such project shall be medical assistance provided under the State plan, and all provisions of this Act not explicitly waived in approving such project shall remain fully applicable to all individuals receiving benefits under the State plan.''.

SEC. 1782. EXTENSION OF QI PROGRAM.

(a) IN GENERAL.—Section 1902(a)(10)(E)(iv) of the Social Security Act (42 U.S.C. 1396b(a)(10)(E)(iv)) is amended—

(1) by striking ''sections 1933 and'' and by inserting ''section''; and

(2) by striking ''December 2010'' and inserting ''December 2012''.

(b) ELIMINATION OF FUNDING LIMITATION.—

(1) IN GENERAL.—Section 1933 of such Act (42 U.S.C. 1396u–3) is amended—

(A) in subsection (a), by striking ''who are selected to receive such assistance under subsection (b)'';

(B) by striking subsections (b), (c), (e), and (g);

(C) in subsection (d), by striking ''furnished in a State'' and all that follows and inserting ''the Federal medical assistance percentage shall be equal to 100 percent.''; and

(D) by redesignating subsections (d) and (f) as subsections (b) and (c), respectively.

(2) CONFORMING AMENDMENT.—Section 1905(b) of such Act (42 U.S.C. 1396d(b)) is amended by striking ''1933(d)'' and inserting ''1933(b)''.

(3) EFFECTIVE DATE.—The amendments made by paragraph (1) shall take effect on January 1, 2011.

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.

(a) IN GENERAL.—Paragraph (19) of section 6103(l) of the Internal Revenue Code of 1986 is amended to read as follows:

''(19) DISCLOSURES TO FACILITATE IDENTIFICATION OF INDIVIDUALS LIKELY TO BE INELIGIBLE FOR LOW-INCOME SUBSIDIES UNDER MEDICARE PRESCRIPTION DRUG PROGRAM TO ASSIST SOCIAL SECURITY ADMINISTRATION'S OUTREACH TO ELIGIBLE INDIVIDUALS.—

''(A) IN GENERAL.—Upon written request from the Commissioner of Social Security, the following return information (including such information disclosed to the Social Security Administration under paragraph (1) or (5)) shall be disclosed to officers and employees of the Social Security Administration, with respect to

any taxpayer identified by the Commissioner of Social Security—

''(i) return information for the applicable year from returns with respect to wages (as defined in section 3121(a) or 3401(a)) and payments of retirement income (as described in paragraph (1) of this subsection),

''(ii) unearned income information and income information of the taxpayer from partnerships, trusts, estates, and subchapter S corporations for the applicable year,

''(iii) if the individual filed an income tax return for the applicable year, the filing status, number of dependents, income from farming, and income from self-employment, on such return,

''(iv) if the individual is a married individual filing a separate return for the applicable year, the social security number (if reasonably available) of the spouse on such return,

''(v) if the individual files a joint return for the applicable year, the social se-

curity number, unearned income information, and income information from partnerships, trusts, estates, and subchapter S corporations of the individual's spouse on such return, and

''(vi) such other return information relating to the individual (or the individual's spouse in the case of a joint return) as is prescribed by the Secretary by regulation as might indicate that the individual is likely to be ineligible for a low-income prescription drug subsidy under section 1860D–14 of the Social Security Act.

''(B) APPLICABLE YEAR.—For the purposes of this paragraph, the term 'applicable year' means the most recent taxable year for which information is available in the Internal Revenue Service's taxpayer information records.

''(C) RESTRICTION ON INDIVIDUALS FOR WHOM DISCLOSURE MAY BE REQUESTED.—The Commissioner of Social Security shall request information under this paragraph only with respect to—

''(i) individuals the Social Security Administration has identified, using all

other reasonably available information, as likely to be eligible for a low-income prescription drug subsidy under section 1860D–14 of the Social Security Act and who have not applied for such subsidy, and

''(ii) any individual the Social Security Administration has identified as a spouse of an individual described in clause (i).

''(D) RESTRICTION ON USE OF DISCLOSED INFORMATION.—Return information disclosed under this paragraph may be used only by officers and employees of the Social Security Administration solely for purposes of identifying individuals likely to be ineligible for a low-income prescription drug subsidy under section 1860D–14 of the Social Security Act for use in outreach efforts under section 1144 of the Social Security Act.''.

(b) SAFEGUARDS.—Paragraph (4) of section 6103(p) of such Code is amended—

(1) by striking ''(l)(19)'' each place it appears, and

(2) by striking ''or (17)'' each place it appears and inserting ''(17), or (19)''.

(c) CONFORMING AMENDMENT.—Paragraph (3) of section 6103(a) of such Code is amended by striking ''(19),''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to disclosures made after the date which is 12 months after the date of the enactment of this Act.

SEC. 1802. COMPARATIVE EFFECTIVENESS RESEARCH TRUST FUND; FINANCING FOR TRUST FUND.

(a) ESTABLISHMENT OF TRUST FUND.—

(1) IN GENERAL.—Subchapter A of chapter 98 of the Internal Revenue Code of 1986 (relating to trust fund code) is amended by adding at the end the following new section:

''**SEC. 9511. HEALTH CARE COMPARATIVE EFFECTIVENESS RESEARCH TRUST FUND.**

''(a) CREATION OF TRUST FUND.—There is established in the Treasury of the United States a trust fund to be known as the 'Health Care Comparative Effectiveness Research Trust Fund' (hereinafter in this section referred to as the 'CERTF'), consisting of such amounts as may be appropriated or credited to such Trust Fund as provided in this section and section 9602(b).

''(b) TRANSFERS TO FUND.—There are hereby appropriated to the Trust Fund the following:

''(1) For fiscal year 2010, $90,000,000.

''(2) For fiscal year 2011, $100,000,000.

''(3) For fiscal year 2012, $110,000,000.

''(4) For each fiscal year beginning with fiscal year 2013—

''(A) an amount equivalent to the net revenues received in the Treasury from the fees imposed under subchapter B of chapter 34 (relating to fees on health insurance and self-insured plans) for such fiscal year; and

''(B) subject to subsection (c)(2), amounts determined by the Secretary of Health and Human Services to be equivalent to the fair share per capita amount computed under subsection (c)(1) for the fiscal year multiplied by the average number of individuals entitled to benefits under part A, or enrolled under part B, of title XVIII of the Social Security Act during such fiscal year.

The amounts appropriated under paragraphs (1), (2), (3), and (4)(B) shall be transferred from the Federal Hospital Insurance Trust Fund and from the Federal Supplementary Medical Insurance Trust Fund (established under section 1841 of such Act), and from the Medicare Prescription Drug Account within such Trust Fund, in

proportion (as estimated by the Secretary) to the total expenditures during such fiscal year that are made under title XVIII of such Act from the respective trust fund or account.

''(c) FAIR SHARE PER CAPITA AMOUNT.—

''(1) COMPUTATION.—

''(A) IN GENERAL.—Subject to subparagraph (B), the fair share per capita amount under this paragraph for a fiscal year (beginning with fiscal year 2013) is an amount computed by the Secretary of Health and Human Services for such fiscal year that, when applied under this section and subchapter B of chapter 34 of the Internal Revenue Code of 1986, will result in revenues to the CERTF of $375,000,000 for the fiscal year.

''(B) ALTERNATIVE COMPUTATION.—

''(i) IN GENERAL.—If the Secretary is unable to compute the fair share per capita amount under subparagraph (A) for a fiscal year, the fair share per capita amount under this paragraph for the fiscal year shall be the default amount determined under clause (ii) for the fiscal year.

''(ii) DEFAULT AMOUNT.—The default amount under this clause for—

''(I) fiscal year 2013 is equal to $2; or

''(II) a subsequent year is equal to the default amount under this clause for the preceding fiscal year increased by the annual percentage increase in the medical care component of the consumer price index (United States city average) for the 12-month period ending with April of the preceding fiscal year.

Any amount determined under subclause (II) shall be rounded to the nearest penny.

''(2) LIMITATION ON MEDICARE FUNDING.—In no case shall the amount transferred under subsection (b)(4)(B) for any fiscal year exceed $90,000,000.

''(d) EXPENDITURES FROM FUND.—

''(1) IN GENERAL.—Subject to paragraph (2), amounts in the CERTF are available, without the need for further appropriations and without fiscal year limitation, to the Secretary of Health and

Human Services for carrying out section 1181 of the Social Security Act.

''(2) ALLOCATION FOR COMMISSION.—Not less than the following amounts in the CERTF for a fiscal year shall be available to carry out the activities of the Comparative Effectiveness Research Commission established under section 1181(b) of the Social Security Act for such fiscal year:

''(A) For fiscal year 2010, $7,000,000.

''(B) For fiscal year 2011, $9,000,000.

''(C) For each fiscal year beginning with 2012, $10,000,000.

Nothing in this paragraph shall be construed as preventing additional amounts in the CERTF from being made available to the Comparative Effectiveness Research Commission for such activities.

''(e) NET REVENUES.—For purposes of this section, the term 'net revenues' means the amount estimated by the Secretary based on the excess of—

''(1) the fees received in the Treasury under subchapter B of chapter 34, over

''(2) the decrease in the tax imposed by chapter 1 resulting from the fees imposed by such subchapter.''.

(2) CLERICAL AMENDMENT.—The table of sections for such subchapter A is amended by adding at the end thereof the following new item:

"Sec. 9511. Health Care Comparative Effectiveness Research Trust Fund.".

(b) FINANCING FOR FUND FROM FEES ON INSURED AND SELF-INSURED HEALTH PLANS.—

(1) GENERAL RULE.—Chapter 34 of the Internal Revenue Code of 1986 is amended by adding at the end the following new subchapter:

"Subchapter B—Insured and Self-Insured Health Plans

"Sec. 4375. Health insurance.
"Sec. 4376. Self-insured health plans.
"Sec. 4377. Definitions and special rules.

"**SEC. 4375. HEALTH INSURANCE.**

"(a) IMPOSITION OF FEE.—There is hereby imposed on each specified health insurance policy for each policy year a fee equal to the fair share per capita amount determined under section 9511(c)(1) multiplied by the average number of lives covered under the policy.

"(b) LIABILITY FOR FEE.—The fee imposed by subsection (a) shall be paid by the issuer of the policy.

"(c) SPECIFIED HEALTH INSURANCE POLICY.—For purposes of this section:

"(1) IN GENERAL.—Except as otherwise provided in this section, the term 'specified health insurance policy' means any accident or health insur-

ance policy issued with respect to individuals residing in the United States.

''(2) EXEMPTION FOR CERTAIN POLICIES.—The term 'specified health insurance policy' does not include any insurance if substantially all of its coverage is of excepted benefits described in section 9832(c).

''(3) TREATMENT OF PREPAID HEALTH COVERAGE ARRANGEMENTS.—

''(A) IN GENERAL.—In the case of any arrangement described in subparagraph (B)—

''(i) such arrangement shall be treated as a specified health insurance policy, and

''(ii) the person referred to in such subparagraph shall be treated as the issuer.

''(B) DESCRIPTION OF ARRANGEMENTS.—An arrangement is described in this subparagraph if under such arrangement fixed payments or premiums are received as consideration for any person's agreement to provide or arrange for the provision of accident or health coverage to residents of the United States, regardless of how such coverage is provided or arranged to be provided.

"**SEC. 4376. SELF-INSURED HEALTH PLANS.**

"(a) IMPOSITION OF FEE.—In the case of any applicable self-insured health plan for each plan year, there is hereby imposed a fee equal to the fair share per capita amount determined under section 9511(c)(1) multiplied by the average number of lives covered under the plan.

"(b) LIABILITY FOR FEE.—

"(1) IN GENERAL.—The fee imposed by subsection (a) shall be paid by the plan sponsor.

"(2) PLAN SPONSOR.—For purposes of paragraph (1) the term 'plan sponsor' means—

"(A) the employer in the case of a plan established or maintained by a single employer,

"(B) the employee organization in the case of a plan established or maintained by an employee organization,

"(C) in the case of—

"(i) a plan established or maintained by 2 or more employers or jointly by 1 or more employers and 1 or more employee organizations,

"(ii) a multiple employer welfare arrangement, or

"(iii) a voluntary employees' beneficiary association described in section 501(c)(9),

the association, committee, joint board of trustees, or other similar group of representatives of the parties who establish or maintain the plan, or

''(D) the cooperative or association described in subsection (c)(2)(F) in the case of a plan established or maintained by such a cooperative or association.

''(c) APPLICABLE SELF-INSURED HEALTH PLAN.—For purposes of this section, the term 'applicable self-insured health plan' means any plan for providing accident or health coverage if—

''(1) any portion of such coverage is provided other than through an insurance policy, and

''(2) such plan is established or maintained—

''(A) by one or more employers for the benefit of their employees or former employees,

''(B) by one or more employee organizations for the benefit of their members or former members,

''(C) jointly by 1 or more employers and 1 or more employee organizations for the benefit of employees or former employees,

''(D) by a voluntary employees' beneficiary association described in section 501(c)(9),

''(E) by any organization described in section 501(c)(6), or

''(F) in the case of a plan not described in the preceding subparagraphs, by a multiple employer welfare arrangement (as defined in section 3(40) of Employee Retirement Income Security Act of 1974), a rural electric cooperative (as defined in section 3(40)(B)(iv) of such Act), or a rural telephone cooperative association (as defined in section 3(40)(B)(v) of such Act).

''**SEC. 4377. DEFINITIONS AND SPECIAL RULES.**

''(a) DEFINITIONS.—For purposes of this subchapter—

''(1) ACCIDENT AND HEALTH COVERAGE.—The term 'accident and health coverage' means any coverage which, if provided by an insurance policy, would cause such policy to be a specified health insurance policy (as defined in section 4375(c)).

''(2) INSURANCE POLICY.—The term 'insurance policy' means any policy or other instrument whereby a contract of insurance is issued, renewed, or extended.

''(3) UNITED STATES.—The term 'United States' includes any possession of the United States.

''(b) TREATMENT OF GOVERNMENTAL ENTITIES.—

''(1) IN GENERAL.—For purposes of this subchapter—

''(A) the term 'person' includes any governmental entity, and

''(B) notwithstanding any other law or rule of law, governmental entities shall not be exempt from the fees imposed by this subchapter except as provided in paragraph (2).

''(2) TREATMENT OF EXEMPT GOVERNMENTAL PROGRAMS.—In the case of an exempt governmental program, no fee shall be imposed under section 4375 or section 4376 on any covered life under such program.

''(3) EXEMPT GOVERNMENTAL PROGRAM DEFINED.—For purposes of this subchapter, the term 'exempt governmental program' means—

''(A) any insurance program established under title XVIII of the Social Security Act,

''(B) the medical assistance program established by title XIX or XXI of the Social Security Act,

''(C) any program established by Federal law for providing medical care (other than through insurance policies) to individuals (or

the spouses and dependents thereof) by reason of such individuals being—

''(i) members of the Armed Forces of the United States, or

''(ii) veterans, and

''(D) any program established by Federal law for providing medical care (other than through insurance policies) to members of Indian tribes (as defined in section 4(d) of the Indian Health Care Improvement Act).

''(c) TREATMENT AS TAX.—For purposes of subtitle F, the fees imposed by this subchapter shall be treated as if they were taxes.

''(d) NO COVER OVER TO POSSESSIONS.—Notwithstanding any other provision of law, no amount collected under this subchapter shall be covered over to any possession of the United States.''.

(2) CLERICAL AMENDMENTS.—

(A) Chapter 34 of such Code is amended by striking the chapter heading and inserting the following:

''CHAPTER 34—TAXES ON CERTAIN INSURANCE POLICIES

''SUBCHAPTER A. POLICIES ISSUED BY FOREIGN INSURERS

''SUBCHAPTER B. INSURED AND SELF-INSURED HEALTH PLANS

''Subchapter A—Policies Issued By Foreign Insurers''.

(B) The table of chapters for subtitle D of such Code is amended by striking the item relating to chapter 34 and inserting the following new item:

''CHAPTER 34—TAXES ON CERTAIN INSURANCE POLICIES''.

(3) EFFECTIVE DATE.—The amendments made by this subsection shall apply with respect to policies and plans for portions of policy or plan years beginning on or after October 1, 2012.

TITLE IX—MISCELLANEOUS PROVISIONS

SEC. 1901. REPEAL OF TRIGGER PROVISION.

Subtitle A of title VIII of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173) is repealed and the provisions of law amended by such subtitle are restored as if such subtitle had never been enacted.

SEC. 1902. REPEAL OF COMPARATIVE COST ADJUSTMENT (CCA) PROGRAM.

Section 1860C–1 of the Social Security Act (42 U.S.C. 1395w–29), as added by section 241(a) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173), is repealed.

SEC. 1903. EXTENSION OF GAINSHARING DEMONSTRATION.

(a) IN GENERAL.—Subsection (d)(3) of section 5007 of the Deficit Reduction Act of 2005 (Public Law 109–171) is amended by inserting ''(or September 30, 2011, in the case of a demonstration project in operation as of October 1, 2008)'' after ''December 31, 2009''.

(b) FUNDING.—

(1) IN GENERAL.—Subsection (f)(1) of such section is amended by inserting ''and for fiscal year 2010, $1,600,000,'' after ''$6,000,000,''.

(2) AVAILABILITY.—Subsection (f)(2) of such section is amended by striking ''2010'' and inserting ''2014 or until expended''.

(c) REPORTS.—

(1) QUALITY IMPROVEMENT AND SAVINGS.—Subsection (e)(3) of such section is amended by striking ''December 1, 2008'' and inserting ''March 31, 2011''.

(2) FINAL REPORT.—Subsection (e)(4) of such section is amended by striking ''May 1, 2010'' and inserting ''March 31, 2013''.

SEC. 1904. GRANTS TO STATES FOR QUALITY HOME VISITATION PROGRAMS FOR FAMILIES WITH YOUNG CHILDREN AND FAMILIES EXPECTING CHILDREN.

Part B of title IV of the Social Security Act (42 U.S.C. 621–629i) is amended by adding at the end the following:

"**Subpart 3—Support for Quality Home Visitation Programs**

"**SEC. 440. HOME VISITATION PROGRAMS FOR FAMILIES WITH YOUNG CHILDREN AND FAMILIES EXPECTING CHILDREN.**

''(a) PURPOSE.—The purpose of this section is to improve the well-being, health, and development of children by enabling the establishment and expansion of high quality programs providing voluntary home visitation for families with young children and families expecting children.

''(b) GRANT APPLICATION.—A State that desires to receive a grant under this section shall submit to the Secretary for approval, at such time and in such manner as the Secretary may require, an application for the grant that includes the following:

''(1) DESCRIPTION OF HOME VISITATION PROGRAMS.—A description of the high quality programs of home visitation for families with young children and families expecting children that will be sup-

ported by a grant made to the State under this section, the outcomes the programs are intended to achieve, and the evidence supporting the effectiveness of the programs.

''(2) RESULTS OF NEEDS ASSESSMENT.—The results of a statewide needs assessment that describes—

''(A) the number, quality, and capacity of home visitation programs for families with young children and families expecting children in the State;

''(B) the number and types of families who are receiving services under the programs;

''(C) the sources and amount of funding provided to the programs;

''(D) the gaps in home visitation in the State, including identification of communities that are in high need of the services; and

''(E) training and technical assistance activities designed to achieve or support the goals of the programs.

''(3) ASSURANCES.—Assurances from the State that—

''(A) in supporting home visitation programs using funds provided under this section,

the State shall identify and prioritize serving communities that are in high need of such services, especially communities with a high proportion of low-income families or a high incidence of child maltreatment;

''(B) the State will reserve 5 percent of the grant funds for training and technical assistance to the home visitation programs using such funds;

''(C) in supporting home visitation programs using funds provided under this section, the State will promote coordination and collaboration with other home visitation programs (including programs funded under title XIX) and with other child and family services, health services, income supports, and other related assistance;

''(D) home visitation programs supported using such funds will, when appropriate, provide referrals to other programs serving children and families; and

''(E) the State will comply with subsection (i), and cooperate with any evaluation conducted under subsection (j).

''(4) OTHER INFORMATION.—Such other information as the Secretary may require.

''(c) ALLOTMENTS.—

''(1) INDIAN TRIBES.—From the amount reserved under subsection (l)(2) for a fiscal year, the Secretary shall allot to each Indian tribe that meets the requirement of subsection (d), if applicable, for the fiscal year the amount that bears the same ratio to the amount so reserved as the number of children in the Indian tribe whose families have income that does not exceed 200 percent of the poverty line bears to the total number of children in such Indian tribes whose families have income that does not exceed 200 percent of the poverty line.

''(2) STATES AND TERRITORIES.—From the amount appropriated under subsection (m) for a fiscal year that remains after making the reservations required by subsection (l), the Secretary shall allot to each State that is not an Indian tribe and that meets the requirement of subsection (d), if applicable, for the fiscal year the amount that bears the same ratio to the remainder of the amount so appropriated as the number of children in the State whose families have income that does not exceed 200 percent of the poverty line bears to the total number of

children in such States whose families have income that does not exceed 200 percent of the poverty line.

''(3) REALLOTMENTS.—The amount of any allotment to a State under a paragraph of this subsection for any fiscal year that the State certifies to the Secretary will not be expended by the State pursuant to this section shall be available for reallotment using the allotment methodology specified in that paragraph. Any amount so reallotted to a State is deemed part of the allotment of the State under this subsection.

''(d) MAINTENANCE OF EFFORT.—Beginning with fiscal year 2011, a State meets the requirement of this subsection for a fiscal year if the Secretary finds that the aggregate expenditures by the State from State and local sources for programs of home visitation for families with young children and families expecting children for the then preceding fiscal year was not less than 100 percent of such aggregate expenditures for the then 2nd preceding fiscal year.

''(e) PAYMENT OF GRANT.—

''(1) IN GENERAL.—The Secretary shall make a grant to each State that meets the requirements of subsections (b) and (d), if applicable, for a fiscal year for which funds are appropriated under sub-

section (m), in an amount equal to the reimbursable percentage of the eligible expenditures of the State for the fiscal year, but not more than the amount allotted to the State under subsection (c) for the fiscal year.

''(2) REIMBURSABLE PERCENTAGE DEFINED.—In paragraph (1), the term 'reimbursable percentage' means, with respect to a fiscal year—

''(A) 85 percent, in the case of fiscal year 2010;

''(B) 80 percent, in the case of fiscal year 2011; or

''(C) 75 percent, in the case of fiscal year 2012 and any succeeding fiscal year.

''(f) ELIGIBLE EXPENDITURES.—

''(1) IN GENERAL.—In this section, the term 'eligible expenditures'—

''(A) means expenditures to provide voluntary home visitation for as many families with young children (under the age of school entry) and families expecting children as practicable, through the implementation or expansion of high quality home visitation programs that—

''(i) adhere to clear evidence-based models of home visitation that have demonstrated positive effects on important program-determined child and parenting outcomes, such as reducing abuse and neglect and improving child health and development;

''(ii) employ well-trained and competent staff, maintain high quality supervision, provide for ongoing training and professional development, and show strong organizational capacity to implement such a program;

''(iii) establish appropriate linkages and referrals to other community resources and supports;

''(iv) monitor fidelity of program implementation to ensure that services are delivered according to the specified model; and

''(v) provide parents with—

''(I) knowledge of age-appropriate child development in cognitive, language, social, emotional, and motor domains (including knowledge of sec-

ond language acquisition, in the case of English language learners);

''(II) knowledge of realistic expectations of age-appropriate child behaviors;

''(III) knowledge of health and wellness issues for children and parents;

''(IV) modeling, consulting, and coaching on parenting practices;

''(V) skills to interact with their child to enhance age-appropriate development;

''(VI) skills to recognize and seek help for issues related to health, developmental delays, and social, emotional, and behavioral skills; and

''(VII) activities designed to help parents become full partners in the education of their children;

''(B) includes expenditures for training, technical assistance, and evaluations related to the programs; and

''(C) does not include any expenditure with respect to which a State has submitted a claim

for payment under any other provision of Federal law.

''(2) PRIORITY FUNDING FOR PROGRAMS WITH STRONGEST EVIDENCE.—

''(A) IN GENERAL.—The expenditures, described in paragraph (1), of a State for a fiscal year that are attributable to the cost of programs that do not adhere to a model of home visitation with the strongest evidence of effectiveness shall not be considered eligible expenditures for the fiscal year to the extent that the total of the expenditures exceeds the applicable percentage for the fiscal year of the allotment of the State under subsection (c) for the fiscal year.

''(B) APPLICABLE PERCENTAGE DEFINED.—In subparagraph (A), the term 'applicable percentage' means, with respect to a fiscal year—

''(i) 60 percent for fiscal year 2010;

''(ii) 55 percent for fiscal year 2011;

''(iii) 50 percent for fiscal year 2012;

''(iv) 45 percent for fiscal year 2013;

or

''(v) 40 percent for fiscal year 2014.

''(g) NO USE OF OTHER FEDERAL FUNDS FOR STATE MATCH.—A State to which a grant is made under this section may not expend any Federal funds to meet the State share of the cost of an eligible expenditure for which the State receives a payment under this section.

''(h) WAIVER AUTHORITY.—

''(1) IN GENERAL.—The Secretary may waive or modify the application of any provision of this section, other than subsection (b) or (f), to an Indian tribe if the failure to do so would impose an undue burden on the Indian tribe.

''(2) SPECIAL RULE.—An Indian tribe is deemed to meet the requirement of subsection (d) for purposes of subsections (c) and (e) if—

''(A) the Secretary waives the requirement; or

''(B) the Secretary modifies the requirement, and the Indian tribe meets the modified requirement.

''(i) STATE REPORTS.—Each State to which a grant is made under this section shall submit to the Secretary an annual report on the progress made by the State in addressing the purposes of this section. Each such report shall include a description of—

''(1) the services delivered by the programs that received funds from the grant;

''(2) the characteristics of each such program, including information on the service model used by the program and the performance of the program;

''(3) the characteristics of the providers of services through the program, including staff qualifications, work experience, and demographic characteristics;

''(4) the characteristics of the recipients of services provided through the program, including the number of the recipients, the demographic characteristics of the recipients, and family retention;

''(5) the annual cost of implementing the program, including the cost per family served under the program;

''(6) the outcomes experienced by recipients of services through the program;

''(7) the training and technical assistance provided to aid implementation of the program, and how the training and technical assistance contributed to the outcomes achieved through the program;

''(8) the indicators and methods used to monitor whether the program is being implemented as designed; and

''(9) other information as determined necessary by the Secretary.

''(j) EVALUATION.—

''(1) IN GENERAL.—The Secretary shall, by grant or contract, provide for the conduct of an independent evaluation of the effectiveness of home visitation programs receiving funds provided under this section, which shall examine the following:

''(A) The effect of home visitation programs on child and parent outcomes, including child maltreatment, child health and development, school readiness, and links to community services.

''(B) The effectiveness of home visitation programs on different populations, including the extent to which the ability of programs to improve outcomes varies across programs and populations.

''(2) REPORTS TO THE CONGRESS.—

''(A) INTERIM REPORT.—Within 3 years after the date of the enactment of this section, the Secretary shall submit to the Congress an interim report on the evaluation conducted pursuant to paragraph (1).

''(B) FINAL REPORT.—Within 5 years after the date of the enactment of this section, the Secretary shall submit to the Congress a final report on the evaluation conducted pursuant to paragraph (1).

''(k) ANNUAL REPORTS TO THE CONGRESS.—The Secretary shall submit annually to the Congress a report on the activities carried out using funds made available under this section, which shall include a description of the following:

''(1) The high need communities targeted by States for programs carried out under this section.

''(2) The service delivery models used in the programs receiving funds provided under this section.

''(3) The characteristics of the programs, including—

''(A) the qualifications and demographic characteristics of program staff; and

''(B) recipient characteristics including the number of families served, the demographic characteristics of the families served, and family retention and duration of services.

''(4) The outcomes reported by the programs.

''(5) The research-based instruction, materials, and activities being used in the activities funded under the grant.

''(6) The training and technical activities, including on-going professional development, provided to the programs.

''(7) The annual costs of implementing the programs, including the cost per family served under the programs.

''(8) The indicators and methods used by States to monitor whether the programs are being been implemented as designed.

''(l) RESERVATIONS OF FUNDS.—From the amounts appropriated for a fiscal year under subsection (m), the Secretary shall reserve—

''(1) an amount equal to 5 percent of the amounts to pay the cost of the evaluation provided for in subsection (j), and the provision to States of training and technical assistance, including the dissemination of best practices in early childhood home visitation; and

''(2) after making the reservation required by paragraph (1), an amount equal to 3 percent of the amount so appropriated, to pay for grants to Indian tribes under this section.

''(m) APPROPRIATIONS.—Out of any money in the Treasury of the United States not otherwise appropriated, there is appropriated to the Secretary to carry out this section—

''(1) $50,000,000 for fiscal year 2010;

''(2) $100,000,000 for fiscal year 2011;

''(3) $150,000,000 for fiscal year 2012;

''(4) $200,000,000 for fiscal year 2013; and

''(5) $250,000,000 for fiscal year 2014.

''(n) INDIAN TRIBES TREATED AS STATES.—In this section, paragraphs (4), (5), and (6) of section 431(a) shall apply.''.

SEC. 1905. IMPROVED COORDINATION AND PROTECTION FOR DUAL ELIGIBLES.

Title XI of the Social Security Act is amended by inserting after section 1150 the following new section:

''IMPROVED COORDINATION AND PROTECTION FOR DUAL ELIGIBLES

''SEC. 1150A. (a) IN GENERAL.—The Secretary shall provide, through an identifiable office or program within the Centers for Medicare & Medicaid Services, for a focused effort to provide for improved coordination between Medicare and Medicaid and protection in the case of dual eligibles (as defined in subsection (e)). The office or program shall—

''(1) review Medicare and Medicaid policies related to enrollment, benefits, service delivery, payment, and grievance and appeals processes under parts A and B of title XVIII, under the Medicare Advantage program under part C of such title, and under title XIX;

''(2) identify areas of such policies where better coordination and protection could improve care and costs; and

''(3) issue guidance to States regarding improving such coordination and protection.

''(b) ELEMENTS.—The improved coordination and protection under this section shall include efforts—

''(1) to simplify access of dual eligibles to benefits and services under Medicare and Medicaid;

''(2) to improve care continuity for dual eligibles and ensure safe and effective care transitions;

''(3) to harmonize regulatory conflicts between Medicare and Medicaid rules with regard to dual eligibles; and

''(4) to improve total cost and quality performance under Medicare and Medicaid for dual eligibles.

''(c) RESPONSIBILITIES.—In carrying out this section, the Secretary shall provide for the following:

''(1) An examination of Medicare and Medicaid payment systems to develop strategies to foster more integrated and higher quality care.

''(2) Development of methods to facilitate access to post-acute and community-based services and to identify actions that could lead to better coordination of community-based care.

''(3) A study of enrollment of dual eligibles in the Medicare Savings Program (as defined in section 1144(c)(7)), under Medicaid, and in the low-income subsidy program under section 1860D–14 to identify methods to more efficiently and effectively reach and enroll dual eligibles.

''(4) An assessment of communication strategies for dual eligibles to determine whether additional informational materials or outreach is needed, including an assessment of the Medicare website, 1–800–MEDICARE, and the Medicare handbook.

''(5) Research and evaluation of areas where service utilization, quality, and access to cost sharing protection could be improved and an assessment of factors related to enrollee satisfaction with services and care delivery.

''(6) Collection (and making available to the public) of data and a database that describe the eli-

gibility, benefit and cost-sharing assistance available to dual eligibles by State.

''(7) Monitoring total combined Medicare and Medicaid program costs in serving dual eligibles and making recommendations for optimizing total quality and cost performance across both programs.

''(8) Coordination of activities relating to Medicare Advantage plans under 1859(b)(6)(B)(ii) and Medicaid.

''(d) PERIODIC REPORTS.—Not later than 1 year after the date of the enactment of this section and every 3 years thereafter the Secretary shall submit to Congress a report on progress in activities conducted under this section.

''(e) DEFINITIONS.—In this section:

''(1) DUAL ELIGIBLE.—The term 'dual eligible' means an individual who is dually eligible for benefits under title XVIII, and medical assistance under title XIX, including such individuals who are eligible for benefits under the Medicare Savings Program (as defined in section 1144(c)(7)).

''(2) MEDICARE; MEDICAID.—The terms 'Medicare' and 'Medicaid' mean the programs under titles XVIII and XIX, respectively.''.

DIVISION C—PUBLIC HEALTH AND WORKFORCE DEVELOPMENT

SEC. 2001. TABLE OF CONTENTS; REFERENCES.

(a) TABLE OF CONTENTS.—The table of contents of this division is as follows:

Sec. 2001. Table of contents; references.
Sec. 2002. Public Health Investment Fund.

TITLE I—COMMUNITY HEALTH CENTERS

Sec. 2101. Increased funding.

TITLE II—WORKFORCE

Subtitle A—Primary Care Workforce

PART 1—NATIONAL HEALTH SERVICE CORPS

Sec. 2201. National Health Service Corps.
Sec. 2202. Authorizations of appropriations.

PART 2—PROMOTION OF PRIMARY CARE AND DENTISTRY

Sec. 2211. Frontline health providers.

"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 assistantship.
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.

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 care professionals.
Sec. 2252. Innovations in interdisciplinary care training.

Part 3—Advisory Committee on Health Workforce Evaluation and Assessment

Sec. 2261. Health workforce evaluation and assessment.

Part 4—Health Workforce Assessment

Sec. 2271. Health workforce assessment.

Part 5—Authorization of Appropriations

Sec. 2281. Authorization of appropriations.

TITLE III—PREVENTION AND WELLNESS

Sec. 2301. Prevention and Wellness.

''TITLE XXXI—PREVENTION AND WELLNESS

''Subtitle A—Prevention and Wellness Trust

''Sec. 3111. Prevention and Wellness Trust.

''Subtitle B—National Prevention and Wellness Strategy

''Sec. 3121. National Prevention and Wellness Strategy.

''Subtitle C—Prevention Task Forces

''Sec. 3131. Task Force on Clinical Preventive Services.
''Sec. 3132. Task Force on Community Preventive Services.

''Subtitle D—Prevention and Wellness Research

''Sec. 3141. Prevention and wellness research activity coordination.
''Sec. 3142. Community prevention and wellness research grants.

"Subtitle E—Delivery of Community Prevention and Wellness Services

"Sec. 3151. Community prevention and wellness services grants.

"Subtitle F—Core Public Health Infrastructure

"Sec. 3161. Core public health infrastructure for State, local, and tribal health departments.
"Sec. 3162. Core public health infrastructure and activities for CDC.

"Subtitle G—General Provisions

"Sec. 3171. Definitions.

TITLE IV—QUALITY AND SURVEILLANCE

Sec. 2401. Implementation of best practices in the delivery of health care.
Sec. 2402. Assistant Secretary for Health Information.
Sec. 2403. Authorization of appropriations.

TITLE V—OTHER PROVISIONS

Subtitle A—Drug Discount for Rural and Other Hospitals

Sec. 2501. Expanded participation in 340B program.
Sec. 2502. Extension of discounts to inpatient drugs.
Sec. 2503. Effective date.

Subtitle B—School-Based Health Clinics

Sec. 2511. School-based health clinics.

Subtitle C—National Medical Device Registry

Sec. 2521. National medical device registry.

Subtitle D—Grants for Comprehensive Programs to Provide Education to Nurses and Create a Pipeline to Nursing

Sec. 2531. Establishment of grant program.

Subtitle E—States Failing to Adhere to Certain Employment Obligations

Sec. 2541. Limitation on Federal funds.

(b) REFERENCES.—Except as otherwise specified, whenever in this division an amendment is expressed in terms of an amendment to a section or other provision, the reference shall be considered to be made to a section or other provision of the Public Health Service Act (42 U.S.C. 201 et seq.).

SEC. 2002. PUBLIC HEALTH INVESTMENT FUND.

(a) ESTABLISHMENT OF FUNDS.—

(1) IN GENERAL.—There is established a fund to be known as the ''Public Health Investment Fund'' (referred to in this section as the ''Fund'').

(2) FUNDING.—

(A) There shall be deposited into the Fund—

(i) for fiscal year 2010, $4,600,000,000;

(ii) for fiscal year 2011, $5,600,000,000;

(iii) for fiscal year 2012, $6,900,000,000;

(iv) for fiscal year 2013, $7,800,000,000;

(v) for fiscal year 2014, $9,000,000,000;

(vi) for fiscal year 2015, $9,400,000,000;

(vii) for fiscal year 2016, $10,100,000,000;

(viii) for fiscal year 2017, $10,800,000,000;

(ix) for fiscal year 2018, $11,800,000,000; and

(x) for fiscal year 2019, $12,700,000,000.

(B) Amounts deposited into the Fund shall be derived from general revenues of the Treasury.

(b) AUTHORIZATION OF APPROPRIATIONS FROM THE FUND.—

(1) NEW FUNDING.—

(A) IN GENERAL.—Amounts in the Fund are authorized to be appropriated by the Committees on Appropriations of the House of Representatives and the Senate for carrying out activities under designated public health provisions.

(B) DESIGNATED PROVISIONS.—For purposes of this paragraph, the term ''designated public health provisions'' means the provisions for which amounts are authorized to be appropriated under section 330(s), 338(c), 338H–1, 799C, 872, or 3111 of the Public Health Service Act, as added by this division.

(2) BASELINE FUNDING.—

(A) IN GENERAL.—Amounts in the Fund are authorized to be appropriated (as described in paragraph (1)) for a fiscal year only if (ex-

cluding any amounts in or appropriated from the Fund)—

(i) the amounts specified in subparagraph (B) for the fiscal year involved are equal to or greater than the amounts specified in subparagraph (B) for fiscal year 2008; and

(ii) the amounts appropriated, out of the general fund of the Treasury, to the Prevention and Wellness Trust under section 3111 of the Public Health Service Act, as added by this division, for the fiscal year involved are equal to or greater than the funds—

(I) appropriated under the heading ''Prevention and Wellness Fund'' in title VIII of division A of the American Recovery and Reinvestment Act of 2009 (Public Law 111–5); and

(II) allocated by the second proviso under such heading for evidence-based clinical and community-based prevention and wellness strategies.

(B) AMOUNTS SPECIFIED.—The amounts specified in this subparagraph, with respect to

a fiscal year, are the amounts appropriated for the following:

(i) Community health centers (including funds appropriated under the authority of section 330 of the Public Health Service Act (42 U.S.C. 254b)).

(ii) The National Health Service Corps Program (including funds appropriated under the authority of section 338 of such Act (42 U.S.C. 254k)).

(iii) The National Health Service Corps Scholarship and Loan Repayment Programs (including funds appropriated under the authority of section 338H of such Act (42 U.S.C. 254q)).

(iv) Primary care loan funds (including funds appropriated for schools of medicine or osteopathic medicine under the authority of section 735(f) of such Act (42 U.S.C. 292y(f))).

(v) Primary care education programs (including funds appropriated under the authority of sections 736, 740, 741, and 747 of such Act (42 U.S.C. 293, 293d, and 293k)).

(vi) Sections 761 and 770 of such Act (42 U.S.C. 294n and 295e).

(vii) Nursing workforce development (including funds appropriated under the authority of title VIII of such Act (42 U.S.C. 296 et seq.)).

(viii) The National Center for Health Statistics (including funds appropriated under the authority of sections 304, 306, 307, and 308 of such Act (42 U.S.C. 242b, 242k, 242l, and 242m)).

(ix) The Agency for Healthcare Research and Quality (including funds appropriated under the authority of title IX of such Act (42 U.S.C. 299 et seq.)).

(3) BUDGETARY IMPLICATIONS.—Amounts appropriated under this section, and outlays flowing from such appropriations, shall not be taken into account for purposes of any budget enforcement procedures including allocations under section 302(a) and (b) of the Balanced Budget and Emergency Deficit Control Act and budget resolutions for fiscal years during which appropriations are made from the Fund.

TITLE I—COMMUNITY HEALTH CENTERS

SEC. 2101. INCREASED FUNDING.

Section 330 of the Public Health Service Act (42 U.S.C. 254b) is amended—

(1) in subsection (r)(1)—

(A) in subparagraph (D), by striking ''and'' at the end;

(B) in subparagraph (E), by striking the period at the end and inserting ''; and''; and

(C) by inserting at the end the following:

''(F) Such sums as may be necessary for each of fiscal years 2013 and 2019.''; and

(2) by inserting after subsection (r) the following:

''(s) ADDITIONAL FUNDING.—For the purpose of carrying out this section, in addition to any other amounts authorized to be appropriated for such purpose, there are authorized to be appropriated, out of any monies in the Public Health Investment Fund, the following:

''(1) For fiscal year 2010, $1,000,000,000.

''(2) For fiscal year 2011, $1,500,000,000.

''(3) For fiscal year 2012, $2,500,000,000.

''(4) For fiscal year 2013, $3,000,000,000.

''(5) For fiscal year 2014, $4,000,000,000.

''(6) For fiscal year 2015, $4,400,000,000.

''(7) For fiscal year 2016, $4,800,000,000.

''(8) For fiscal year 2017, $5,300,000,000.

''(9) For fiscal year 2018, $5,900,000,000.

''(10) For fiscal year 2019, $6,400,000,000.''.

TITLE II—WORKFORCE

Subtitle A—Primary Care Workforce

PART 1—NATIONAL HEALTH SERVICE CORPS

SEC. 2201. NATIONAL HEALTH SERVICE CORPS.

(a) FULFILLMENT OF OBLIGATED SERVICE REQUIREMENT THROUGH HALF-TIME SERVICE.—

(1) WAIVERS.—Subsection (i) of section 331 (42 U.S.C. 254d) is amended—

(A) in paragraph (1), by striking ''In carrying out subpart III'' and all that follows through the period and inserting ''In carrying out subpart III, the Secretary may, in accordance with this subsection, issue waivers to individuals who have entered into a contract for obligated service under the Scholarship Program or the Loan Repayment Program under which the individuals are authorized to satisfy the requirement of obligated service through providing clinical practice that is half-time.'';

(B) in paragraph (2)—

(i) in subparagraphs (A)(ii) and (B), by striking ''less than full time'' each place it appears and inserting ''half time'';

(ii) in subparagraphs (C) and (F), by striking ''less than full-time service'' each place it appears and inserting ''half-time service''; and

(iii) by amending subparagraphs (D) and (E) to read as follows:

''(D) the entity and the Corps member agree in writing that the Corps member will perform half-time clinical practice;

''(E) the Corps member agrees in writing to fulfill all of the service obligations under section 338C through half-time clinical practice and either—

''(i) double the period of obligated service; or

''(ii) in the case of contracts entered into under section 338B, accept a minimum service obligation of 2 years with an award amount equal to 50 percent of the amount that would otherwise be payable for full-time service; and''; and

(C) in paragraph (3), by striking ''In evaluating a demonstration project described in paragraph (1)'' and inserting ''In evaluating waivers issued under paragraph (1)''.

(2) DEFINITIONS.—Subsection (j) of section 331 (42 U.S.C. 254d) is amended by adding at the end the following:

''(5) The terms 'full time' and 'full-time' mean a minimum of 40 hours per week in a clinical practice, for a minimum of 45 weeks per year.

''(6) The terms 'half time' and 'half-time' mean a minimum of 20 hours per week (not to exceed 39 hours per week) in a clinical practice, for a minimum of 45 weeks per year.''.

(b) REAPPOINTMENT TO NATIONAL ADVISORY COUNCIL .—Section 337(b)(1) (42 U.S.C. 254j(b)(1)) is amended by striking ''Members may not be reappointed to the Council.''.

(c) LOAN REPAYMENT AMOUNT.—Section 338B(g)(2)(A) is amended (42 U.S.C. 254l–1(g)(2)(A)) by striking ''$35,000'' and inserting ''$50,000, plus, beginning with fiscal year 2012, an amount determined by the Secretary on an annual basis to reflect inflation,''.

(d) TREATMENT OF TEACHING AS OBLIGATED SERVICE.—Subsection (a) of section 338C (42 U.S.C. 254m)

is amended by adding at the end the following: ''The Secretary may treat teaching as clinical practice for up to 20 percent of such period of obligated service.''.

SEC. 2202. AUTHORIZATIONS OF APPROPRIATIONS.

(a) NATIONAL HEALTH SERVICE CORPS PROGRAM.—Section 338 (42 U.S.C. 254k) is amended—

(1) in subsection (a), by striking ''2012'' and inserting ''2019''; and

(2) by adding at the end the following:

''(c) For the purpose of carrying out this subpart, in addition to any other amounts authorized to be appropriated for such purpose, there are authorized to be appropriated, out of any monies in the Public Health Investment Fund, the following:

''(1) $63,000,000 for fiscal year 2010.

''(2) $66,000,000 for fiscal year 2011.

''(3) $70,000,000 for fiscal year 2012.

''(4) $73,000,000 for fiscal year 2013.

''(5) $77,000,000 for fiscal year 2014.

''(6) $81,000,000 for fiscal year 2015.

''(7) $85,000,000 for fiscal year 2016.

''(8) $89,000,000 for fiscal year 2017.

''(9) $94,000,000 for fiscal year 2018.

''(10) $98,000,000 for fiscal year 2019.''.

(b) SCHOLARSHIP AND LOAN REPAYMENT PROGRAMS.—Subpart III of part D of title III of the Public Health Service Act (42 U.S.C. 254l et seq.) is amended—

(1) in section 338H(a)—

(A) in paragraph (4), by striking ''and'' at the end;

(B) in paragraph (5), by striking the period at the end and inserting ''; and''; and

(C) by adding at the end the following:

''(6) for fiscal years 2013 and 2019, such sums as may be necessary.''; and

(2) by inserting after section 338H the following:

''**SEC. 338H–1. ADDITIONAL FUNDING.**

''For the purpose of carrying out this subpart, in addition to any other amounts authorized to be appropriated for such purpose, there are authorized to be appropriated, out of any monies in the Public Health Investment Fund, the following:

''(1) $254,000,000 for fiscal year 2010.

''(2) $266,000,000 for fiscal year 2011.

''(3) $278,000,000 for fiscal year 2012.

''(4) $292,000,000 for fiscal year 2013.

''(5) $306,000,000 for fiscal year 2014.

''(6) $321,000,000 for fiscal year 2015.

''(7) $337,000,000 for fiscal year 2016.

''(8) $354,000,000 for fiscal year 2017.

''(9) $372,000,000 for fiscal year 2018.

''(10) $391,000,000 for fiscal year 2019.''.

PART 2—PROMOTION OF PRIMARY CARE AND DENTISTRY

SEC. 2211. FRONTLINE HEALTH PROVIDERS.

Part D of title III (42 U.S.C. 254b et seq.) is amended by adding at the end the following:

''Subpart XI—Health Professional Needs Areas

''SEC. 340H. IN GENERAL.

''(a) PROGRAM.—The Secretary, acting through the Administrator of the Health Resources and Services Administration, shall establish a program, to be known as the Frontline Health Providers Loan Repayment Program, to address unmet health care needs in health professional needs areas through loan repayments under section 340I.

''(b) DESIGNATION OF HEALTH PROFESSIONAL NEEDS AREAS.—

''(1) IN GENERAL.—In this subpart, the term 'health professional needs area' means an area, population, or facility that is designated by the Secretary in accordance with paragraph (2).

''(2) DESIGNATION.—To be designated by the Secretary as a health professional needs area under this subpart:

''(A) In the case of an area, the area must be a rational area for the delivery of health services.

''(B) The area, population, or facility must have, in one or more health disciplines, specialties, or subspecialties for the population served, as determined by the Secretary—

''(i) insufficient capacity of health professionals; or

''(ii) high needs for health services.

''(C) With respect to the delivery of primary health services, the area, population, or facility must not include a health professional shortage area (as designated under section 332), except that the area, population, or facility may include such a health professional shortage area to which no member of the National Health Service Corps is currently assigned.

''(c) ELIGIBILITY.—To be eligible to participate in the Program, an individual shall—

''(1) hold a degree in a course of study or program (approved by the Secretary) from a school defined in section 799B(1)(A) (other than a school of public health);

''(2) hold a degree in a course of study or program (approved by the Secretary) from a school or program defined in subparagraph (C), (D), or (E)(4) of section 799B(1), as designated by the Secretary;

''(3) be enrolled as a full-time student—

''(A) in a school or program defined in subparagraph (C), (D), or (E)(4) of section 799B(1), as designated by the Secretary, or a school described in paragraph (1); and

''(B) in the final year of a course of study or program, offered by such school or program and approved by the Secretary, leading to a degree in a discipline referred to in subparagraph (A) (other than a graduate degree in public health), (C), (D), or (E)(4) of section 799B(1);

''(4) be a practitioner described in section 1842(b)(18)(C) or 1848(k)(3)(B)(iii) or (iv) of the Social Security Act; or

''(5) be a practitioner in the field of respiratory therapy, medical technology, or radiologic technology.

''(d) DEFINITION.—In this subpart, the term 'primary health services' has the meaning given to such term in section 331(a)(3)(D).

"**SEC. 340I. LOAN REPAYMENTS.**

''(a) LOAN REPAYMENTS.—The Secretary, acting through the Administrator of the Health Resources and Services Administration, shall enter into contracts with individuals under which—

''(1) the individual agrees—

''(A) to serve as a full-time primary health services provider or as a full-time or part-time provider of other health services for a period of time equal to 2 years or such longer period as the individual may agree to;

''(B) to serve in a health professional needs area in a health discipline, specialty, or a subspecialty for which the area, population, or facility is designated as a health professional needs area under section 340H; and

''(C) in the case of an individual described in subsection 340H(c)(3) who is in the final year of study and who has accepted employ-

ment as primary health services provider or provider of other health services in accordance with subparagraphs (A) and (B), to complete the education or training and maintain an acceptable level of academic standing (as determined by the educational institution offering the course of study or training); and

''(2) the Secretary agrees to pay, for each year of such service, an amount on the principal and interest of the undergraduate or graduate educational loans (or both) of the individual that is not more than 50 percent of the average award made under the National Health Service Corps Loan Repayment Program under subpart III in that year.

''(b) PRACTICE SETTING.—A contract entered into under this section shall allow the individual receiving the loan repayment to satisfy the service requirement described in subsection (a)(1) through employment in a solo or group practice, a clinic, an accredited public or private nonprofit hospital, or any other health care entity, as deemed appropriate by the Secretary.

''(c) APPLICATION OF CERTAIN PROVISIONS.—The provisions of subpart III of part D shall, except as inconsistent with this section, apply to the loan repayment program under this subpart in the same manner and to the

same extent as such provisions apply to the National Health Service Corps Loan Repayment Program established under section 338B.

''(d) INSUFFICIENT NUMBER OF APPLICANTS.—If there are an insufficient number of applicants for loan repayments under this section to obligate all appropriated funds, the Secretary shall transfer the unobligated funds to the National Health Service Corps for the purpose of—

''(1) recruitment of sufficient applicants for the National Health Service Corps for the following year; or

''(2) making additional loan repayments under section 338B if there is an excess number of qualified applicants for loan repayments under such section.

''**SEC. 340J. REPORT.**

''The Secretary shall submit to the Congress an annual report on the program carried out under this subpart.

''**SEC. 340K. ALLOCATION.**

''Of the amount of funds obligated under this subpart each fiscal year for loan repayments—

''(1) 90 percent shall be for physicians and other health professionals providing primary health services; and

''(2) 10 percent shall be for health professionals not described in paragraph (1).''.

SEC. 2212. PRIMARY CARE STUDENT LOAN FUNDS.

(a) LOAN PROVISIONS.—Section 722 (42 U.S.C. 292r) is amended by striking subsection (e) and inserting the following:

''(e) RATE OF INTEREST.—Such loans shall bear interest, on the unpaid balance of the loan, computed only for periods for which the loan is repayable, at the rate of 2 percentage points less than the applicable rate of interest described in section 427A(l)(1) of the Higher Education Act of 1965 per year.''.

(b) MEDICAL SCHOOLS AND PRIMARY HEALTH CARE.—Subsection (a) of section 723 (42 U.S.C. 292s) is amended—

(1) in paragraph (1), by striking subparagraph (B) and inserting the following:

''(B) to practice in such care for 10 years (including residency training in primary health care) or through the date on which the loan is repaid in full, whichever occurs first.''; and

(2) by striking paragraph (3) and inserting the following:

''(3) NONCOMPLIANCE BY STUDENT.—If an individual fails to comply with an agreement entered

into pursuant to paragraph (1), such agreement shall provide that the total interest to be paid on the loan, over the course of the loan period, shall equal the total amount of interest that would have been incurred by the individual if, from the outset of the loan, the loan was repayable at the rate of interest described in section 427A(l)(1) of the Higher Education Act of 1965 per year instead of the rate of interest described in section 722(e).''.

(c) STUDENT LOAN GUIDELINES.—

(1) IN GENERAL.—Section 735 (42 U.S.C. 292y) is amended—

(A) by redesignating subsection (f) as subsection (g); and

(B) by inserting after subsection (e) the following:

''(f) DETERMINATION OF FINANCIAL NEED.—The Secretary—

''(1) may require, or authorize a school or other entity to require, the submission of financial information to determine the financial resources available to any individual seeking assistance under this subpart; and

''(2) shall take into account the extent to which such individual is financially independent in deter-

mining whether to require or authorize the submission of such information regarding such individual's family members.''.

(2) REVISED GUIDELINES.—The Secretary of Health and Human Services shall—

(A) strike the second sentence of section 57.206(b) of title 42, Code of Federal Regulations; and

(B) make such other revisions to guidelines and regulations in effect as of the date of the enactment of this Act as may be necessary for consistency with the amendments made by paragraph (1).

SEC. 2213. TRAINING IN FAMILY MEDICINE, GENERAL INTERNAL MEDICINE, GENERAL PEDIATRICS, GERIATRICS, AND PHYSICIAN ASSISTANTSHIP.

Section 747 (42 U.S.C. 293k) is amended—

(1) by amending the section heading to read as follows: ''**PRIMARY CARE TRAINING AND ENHANCEMENT**'';

(2) by redesignating subsection (e) as subsection (f); and

(3) by striking subsections (a) through (d) and inserting the following:

''(a) PROGRAM.—The Secretary shall establish a primary care training and capacity building program consisting of awarding grants and contracts under subsections (b) and (c).

''(b) SUPPORT AND DEVELOPMENT OF PRIMARY CARE TRAINING PROGRAMS.—

''(1) IN GENERAL.—The Secretary shall make grants to, or enter into contracts with, eligible entities—

''(A) to plan, develop, operate, or participate in an accredited professional training program, including an accredited residency or internship program, in the field of family medicine, general internal medicine, general pediatrics, or geriatrics for medical students, interns, residents, or practicing physicians;

''(B) to provide financial assistance in the form of traineeships and fellowships to medical students, interns, residents, or practicing physicians, who are participants in any such program, and who plan to specialize or work in family medicine, general internal medicine, general pediatrics, or geriatrics;

''(C) to plan, develop, operate, or participate in an accredited program for the training

of physicians who plan to teach in family medicine, general internal medicine, general pediatrics, or geriatrics training programs including in community-based settings;

''(D) to provide financial assistance in the form of traineeships and fellowships to practicing physicians who are participants in any such programs and who plan to teach in a family medicine, general internal medicine, general pediatrics, or geriatrics training program; and

''(E) to plan, develop, operate, or participate in an accredited program for physician assistant education, and for the training of individuals who plan to teach in programs to provide such training.

''(2) ELIGIBILITY.—To be eligible for a grant or contract under paragraph (1), an entity shall be—

''(A) an accredited school of medicine or osteopathic medicine, public or nonprofit private hospital, or physician assistant training program;

''(B) a public or private nonprofit entity; or

''(C) a consortium of 2 or more entities described in subparagraphs (A) and (B).

''(c) CAPACITY BUILDING IN PRIMARY CARE.—

''(1) IN GENERAL.—The Secretary shall make grants to or enter into contracts with eligible entities to establish, maintain, or improve—

''(A) academic administrative units (including departments, divisions, or other appropriate units) in the specialties of family medicine, general internal medicine, general pediatrics, or geriatrics; or

''(B) programs that improve clinical teaching in such specialties.

''(2) ELIGIBILITY.—To be eligible for a grant or contract under paragraph (1), an entity shall be an accredited school of medicine or osteopathic medicine.

''(d) PREFERENCE.—In awarding grants or contracts under this section, the Secretary shall give preference to entities that have a demonstrated record of the following:

''(1) Training the greatest percentage, or significantly improving the percentage, of health care professionals who provide primary care.

''(2) Training individuals who are from underrepresented minority groups or disadvantaged backgrounds.

''(3) A high rate of placing graduates in practice settings having the principal focus of serving in underserved areas or populations experiencing health disparities (including serving patients eligible for medical assistance under title XIX of the Social Security Act or for child health assistance under title XXI of such Act or those with special health care needs).

''(4) Supporting teaching programs that address the health care needs of vulnerable populations.

''(e) REPORT.—The Secretary shall submit to the Congress an annual report on the program carried out under this section.

''(f) DEFINITION.—In this section, the term 'health disparities' has the meaning given the term in section 3171.''.

SEC. 2214. TRAINING OF MEDICAL RESIDENTS IN COMMUNITY-BASED SETTINGS.

Title VII (42 U.S.C. 292 et seq.) is amended—

(1) by redesignating section 748 as 749A; and

(2) by inserting after section 747 the following:

"**SEC. 748. TRAINING OF MEDICAL RESIDENTS IN COMMUNITY-BASED SETTINGS.**

"(a) PROGRAM.—The Secretary shall establish a program for the training of medical residents in community-based settings consisting of awarding grants or contracts under this section.

"(b) DEVELOPMENT AND OPERATION OF COMMUNITY-BASED PROGRAMS.—The Secretary shall make grants to, or enter into contracts with, eligible entities—

"(1) to plan and develop a new primary care residency training program, which may include—

"(A) planning and developing curricula;

"(B) recruiting and training residents and faculty; and

"(C) other activities designated to result in accreditation of such a program; or

"(2) to operate or participate in an established primary care residency training program, which may include—

"(A) planning and developing curricula;

"(B) recruitment and training of residents; and

"(C) retention of faculty.

"(c) ELIGIBLE ENTITY.—To be eligible to receive a grant or contract under subsection (b), an entity shall—

''(1) be designated as a recipient of payment for the direct costs of medical education under section 1886(k) of the Social Security Act;

''(2) be designated as an approved teaching health center under section 1502(d) of the America's Affordable Health Choices Act of 2009 and continuing to participate in the demonstration project under such section; or

''(3) be an applicant for designation described in paragraph (1) or (2) and have demonstrated to the Secretary appropriate involvement of an accredited teaching hospital to carry out the inpatient responsibilities associated with a primary care residency training program.

''(d) PREFERENCES.—In awarding grants and contracts under paragraph (1) or (2) of subsection (b), the Secretary shall give preference to entities that—

''(1) support teaching programs that address the health care needs of vulnerable populations; or

''(2) are a Federally qualified health center (as defined in section 1861(aa)(4) of the Social Security Act) or a rural health clinic (as defined in section 1861(aa)(2) of such Act).

''(e) ADDITIONAL PREFERENCES FOR ESTABLISHED PROGRAMS.—In awarding grants and contracts under

subsection (b)(2), the Secretary shall give preference to entities that have a demonstrated record of training—

''(1) a high or significantly improved percentage of health care professionals who provide primary care;

''(2) individuals who are from underrepresented minority groups or disadvantaged backgrounds; or

''(3) individuals who practice in settings having the principal focus of serving underserved areas or populations experiencing health disparities (including serving patients eligible for medical assistance under title XIX of the Social Security Act or for child health assistance under title XXI of such Act or those with special health care needs).

''(f) PERIOD OF AWARDS.—

''(1) IN GENERAL.—The period of a grant or contract under this section—

''(A) shall not exceed 2 years for awards under subsection (b)(1); and

''(B) shall not exceed 5 years for awards under subsection (b)(2).

''(2) SPECIAL RULES.—

''(A) An award of a grant or contract under subsection (b)(1) shall not be renewed.

''(B) The period of a grant or contract awarded to an entity under subsection (b)(2) shall not overlap with the period of any grant or contact awarded to the same entity under subsection (b)(1).

''(g) REPORT.—The Secretary shall submit to the Congress an annual report on the program carried out under this section.

''(h) DEFINITIONS.—In this section:

''(1) PRIMARY CARE RESIDENCY TRAINING PROGRAM.—The term 'primary care residency training program' means an approved medical residency training program described in section 1886(h)(5)(A) of the Social Security Act that is—

''(A) in the case of entities seeking awards under subsection (b)(1), actively applying to be accredited by the Accreditation Council for Graduate Medical Education; or

''(B) in the case of entities seeking awards under subsection (b)(2), so accredited.

''(2) HEALTH DISPARITIES.—The term 'health disparities' has the meaning given the term in section 3171.''.

SEC. 2215. TRAINING FOR GENERAL, PEDIATRIC, AND PUBLIC HEALTH DENTISTS AND DENTAL HYGIENISTS.

Title VII (42 U.S.C. 292 et seq.) is amended—

(1) in section 791(a)(1), by striking ''747 and 750'' and inserting ''747, 749, and 750''; and

(2) by inserting after section 748, as added, the following:

''**SEC. 749. TRAINING FOR GENERAL, PEDIATRIC, AND PUBLIC HEALTH DENTISTS AND DENTAL HYGIENISTS.**

''(a) PROGRAM.—The Secretary shall establish a dental medicine training program consisting of awarding grants and contracts under this section.

''(b) SUPPORT AND DEVELOPMENT OF DENTAL TRAINING PROGRAMS.—The Secretary shall make grants to, or enter into contracts with, eligible entities—

''(1) to plan, develop, operate, or participate in an accredited professional training program for oral health professionals;

''(2) to provide financial assistance to oral health professionals who are in need thereof, who are participants in any such program, and who plan to work in general, pediatric, or public heath dentistry, or dental hygiene;

''(3) to plan, develop, operate, or participate in a program for the training of oral health professionals who plan to teach in general, pediatric, or public health dentistry, or dental hygiene;

''(4) to provide financial assistance in the form of traineeships and fellowships to oral health professionals who plan to teach in general, pediatric, or public health dentistry or dental hygiene;

''(5) to establish, maintain, or improve—

''(A) academic administrative units (including departments, divisions, or other appropriate units) in the specialties of general, pediatric, or public health dentistry; or

''(B) programs that improve clinical teaching in such specialties.

''(6) to plan, develop, operate, or participate in predoctoral and postdoctoral training in general, pediatric, or public health dentistry programs, or training for dental hygienists;

''(7) to plan, develop, operate, or participate in a loan repayment program for full-time faculty in a program of general, pediatric, or public health dentistry; and

''(8) to provide technical assistance to pediatric dental training programs in developing and imple-

menting instruction regarding the oral health status, dental care needs, and risk-based clinical disease management of all pediatric populations with an emphasis on underserved children.

''(c) ELIGIBILITY.—To be eligible for a grant or contract under subsection (a), an entity shall be—

''(1) an accredited school of dentistry, training program in dental hygiene, or public or nonprofit private hospital;

''(2) a training program in dental hygiene at an accredited institution of higher education;

''(3) a public or private nonprofit entity; or

''(4) a consortium of—

''(A) 2 or more of the entities described in paragraphs (1) through (3); and

''(B) an accredited school of public health.

''(d) PREFERENCE.—In awarding grants or contracts under this section, the Secretary shall give preference to entities that have a demonstrated record of the following:

''(1) Training the greatest percentage, or significantly improving the percentage, of oral health professionals who practice general, pediatric, or public health dentistry.

''(2) Training individuals who are from underrepresented minority groups or disadvantaged backgrounds.

''(3) A high rate of placing graduates in practice settings having the principal focus of serving in underserved areas or populations experiencing health disparities (including serving patients eligible for medical assistance under title XIX of the Social Security Act or for child health assistance under title XXI of such Act or those with special health care needs).

''(4) Supporting teaching programs that address the dental needs of vulnerable populations.

''(5) Providing instruction regarding the oral health status, dental care needs, and risk-based clinical disease management of all pediatric populations with an emphasis on underserved children.

''(e) REPORT.—The Secretary shall submit to the Congress an annual report on the program carried out under this section.

''(f) DEFINITION.—In this section:

''(1) The term 'health disparities' has the meaning given the term in section 3171.

''(2) The term 'oral health professional' means an individual training or practicing—

''(A) in general dentistry, pediatric dentistry, public health dentistry, or dental hygiene; or

''(B) another dental medicine specialty, as deemed appropriate by the Secretary.''.

SEC. 2216. AUTHORIZATION OF APPROPRIATIONS.

(a) IN GENERAL.—Part F of title VII (42 U.S.C. 295j et seq.) is amended by adding at the end the following:

''**SEC. 799C. FUNDING THROUGH PUBLIC HEALTH INVESTMENT FUND.**

''(a) PROMOTION OF PRIMARY CARE AND DENTISTRY.—For the purpose of carrying out subpart XI of part D of title III and sections 723, 747, 748, and 749, in addition to any other amounts authorized to be appropriated for such purpose, there is authorized to be appropriated, out of any monies in the Public Health Investment Fund, the following:

''(1) $240,000,000 for fiscal year 2010.

''(2) $253,000,000 for fiscal year 2011.

''(3) $265,000,000 for fiscal year 2012.

''(4) $278,000,000 for fiscal year 2013.

''(5) $292,000,000 for fiscal year 2014.

''(6) $307,000,000 for fiscal year 2015.

''(7) $322,000,000 for fiscal year 2016.

''(8) $338,000,000 for fiscal year 2017.

''(9) $355,000,000 for fiscal year 2018.

''(10) $373,000,000 for fiscal year 2019.''.

(b) EXISTING AUTHORIZATIONS OF APPROPRIATIONS.—

(1) SECTION 735.—Paragraph (1) of section 735(g), as so redesignated, is amended by inserting ''and such sums as may be necessary for subsequent years through fiscal year 2019'' before the period at the end.

(2) SECTION 747.—Subsection (f), as so redesignated, of section 747 (42 U.S.C. 293k) is amended by striking ''2002'' and inserting ''2019''.

Subtitle B—Nursing Workforce

SEC. 2221. AMENDMENTS TO PUBLIC HEALTH SERVICE ACT.

(a) DEFINITIONS.—Section 801 (42 U.S.C. 296 et seq.) is amended—

(1) in paragraph (1), by inserting ''nurse-managed health centers'' after ''nursing centers,''; and

(2) by adding at the end the following:

''(16) NURSE-MANAGED HEALTH CENTER.—The term 'nurse-managed health center' means a nurse-practice arrangement, managed by advanced practice nurses, that provides primary care or wellness services to underserved or vulnerable popu-

lations and is associated with an accredited school of nursing, Federally qualified health center, or independent nonprofit health or social services agency.''.

(a) GRANTS FOR HEALTH PROFESSIONS EDUCATION.—Title VIII (42 U.S.C. 296 et seq.) is amended by striking section 807.

(b) ADVANCED EDUCATION NURSING GRANTS.—Section 811(f) (42 U.S.C. 296j(f)) is amended—

(1) by striking paragraph (2);

(2) by redesignating paragraph (3) as paragraph (2); and

(3) in paragraph (2), as so redesignated, by striking ''that agrees'' and all that follows through the end and inserting: ''that agrees to expend the award—

''(A) to train advanced education nurses who will practice in health professional shortage areas designated under section 332; or

''(B) to increase diversity among advanced education nurses.''.

(c) NURSE EDUCATION, PRACTICE, AND RETENTION GRANTS.—Section 831 (42 U.S.C. 296p) is amended—

(1) in subsection (b), by amending paragraph (3) to read as follows:

''(3) providing coordinated care, quality care, and other skills needed to practice nursing;''; and

(2) by striking subsection (e) and redesignating subsections (f) through (h) as subsections (e) through (g), respectively.

(d) STUDENT LOANS.—Subsection (a) of section 836 (42 U.S.C. 297b) is amended—

(1) by striking ''$2,500'' and inserting ''$3,300'';

(2) by striking ''$4,000'' and inserting ''$5,200'';

(3) by striking ''$13,000'' and inserting ''$17,000''; and

(4) by adding at the end the following: ''Beginning with fiscal year 2012, the dollar amounts specified in this subsection shall be adjusted by an amount determined by the Secretary on an annual basis to reflect inflation.''.

(e) LOAN REPAYMENT.—Section 846 (42 U.S.C. 297n) is amended—

(1) in subsection (a), by amending paragraph (3) to read as follows:

''(3) who enters into an agreement with the Secretary to serve for a period of not less than 2 years—

''(A) as a nurse at a health care facility with a critical shortage of nurses; or

''(B) as a faculty member at an accredited school of nursing;''; and

(2) in subsection (g)(1), by striking ''to provide health services'' each place it appears and inserting ''to provide health services or serve as a faculty member''.

(f) NURSE FACULTY LOAN PROGRAM.—Paragraph (2) of section 846A(c) (42 U.S.C. 297n–1(c)) is amended by striking ''$30,000'' and all that follows through the semicolon and inserting ''$35,000, plus, beginning with fiscal year 2012, an amount determined by the Secretary on an annual basis to reflect inflation;''.

(g) PUBLIC SERVICE ANNOUNCEMENTS.—Title VIII (42 U.S.C. 296 et seq.) is amended by striking part H.

(h) TECHNICAL AND CONFORMING AMENDMENTS.—Title VIII (42 U.S.C. 296 et seq.) is amended—

(1) by redesignating section 810 (relating to prohibition against discrimination by schools on the basis of sex) as section 809 and moving such section so that it follows section 808;

(2) in sections 835, 836, 838, 840, and 842, by striking the term ''this subpart'' each place it appears and inserting ''this part'';

(3) in section 836(h), by striking the last sentence;

(4) in section 836, by redesignating subsection (l) as subsection (k);

(5) in section 839, by striking ''839'' and all that follows through ''(a)'' and inserting ''839. (a)'';

(6) in section 835(b), by striking ''841'' each place it appears and inserting ''871'';

(7) by redesignating section 841 as section 871, moving part F to the end of the title, and redesignating such part as part H;

(8) in part G—

(A) by redesignating section 845 as section 851; and

(B) by redesignating part G as part F; and

(9) in part I—

(A) by redesignating section 855 as section 861; and

(B) by redesignating part I as part G.

(i) FUNDING.—

(1) IN GENERAL.—Part H, as redesignated, of title VIII is amended by adding at the end the following:

"**SEC. 872. FUNDING THROUGH PUBLIC HEALTH INVESTMENT FUND.**

"For the purpose of carrying out this title, in addition to any other amounts authorized to be appropriated for such purpose, there are authorized to be appropriated, out of any monies in the Public Health Investment Fund, the following:

"(1) $115,000,000 for fiscal year 2010.

"(2) $122,000,000 for fiscal year 2011.

"(3) $127,000,000 for fiscal year 2012.

"(4) $134,000,000 for fiscal year 2013.

"(5) $140,000,000 for fiscal year 2014.

"(6) $147,000,000 for fiscal year 2015.

"(7) $154,000,000 for fiscal year 2016.

"(8) $162,000,000 for fiscal year 2017.

"(9) $170,000,000 for fiscal year 2018.

"(10) $179,000,000 for fiscal year 2019.".

(2) EXISTING AUTHORIZATIONS OF APPROPRIATIONS.—

(A) SECTIONS 831, 846, 846A, AND 861.—Sections 831(g) (as so redesignated), 846(i)(1) (42 U.S.C. 297n(i)(1)), 846A(f) (42 U.S.C. 297n–1(f)), and 861(e) (as so redesignated) are amended by striking "2007" each place it appears and inserting "2019".

(B) SECTION 871.—Section 871, as so redesignated, is amended to read as follows:

"**SEC. 871. FUNDING.**

"For the purpose of carrying out parts B, C, and D (subject to section 845(g)), there are authorized to be appropriated such sums as may be necessary for each fiscal year through fiscal year 2019.".

Subtitle C—Public Health Workforce

SEC. 2231. PUBLIC HEALTH WORKFORCE CORPS.

Part D of title III (42 U.S.C. 254b et seq.), as amended by section 2211, is amended by adding at the end the following:

"**Subpart XII—Public Health Workforce**

"**SEC. 340L. PUBLIC HEALTH WORKFORCE CORPS.**

"(a) ESTABLISHMENT.—There is established, within the Service, the Public Health Workforce Corps (in this subpart referred to as the 'Corps'), for the purpose of ensuring an adequate supply of public health professionals throughout the Nation. The Corps shall consist of—

"(1) such officers of the Regular and Reserve Corps of the Service as the Secretary may designate; and

"(2) such civilian employees of the United States as the Secretary may appoint.

''(b) ADMINISTRATION.—Except as provided in subsection (c), the Secretary shall carry out this subpart acting through the Administrator of the Health Resources and Services Administration.

''(c) PLACEMENT AND ASSIGNMENT.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall develop a methodology for placing and assigning Corps participants as public health professionals. Such methodology may allow for placing and assigning such participants in State, local, and tribal health departments and Federally qualified health centers (as defined in section 1861(aa)(4) of the Social Security Act).

''(d) APPLICATION OF CERTAIN PROVISIONS.—The provisions of subpart II shall, except as inconsistent with this subpart, apply to the Public Health Workforce Corps in the same manner and to the same extent as such provisions apply to the National Health Service Corps established under section 331.

''(e) REPORT.—The Secretary shall submit to the Congress an annual report on the programs carried out under this subpart.

"**SEC. 340M. PUBLIC HEALTH WORKFORCE SCHOLARSHIP PROGRAM.**

''(a) ESTABLISHMENT.—The Secretary shall establish the Public Health Workforce Scholarship Program (referred to in this section as the 'Program') for the purpose described in section 340L(a).

''(b) ELIGIBILITY.—To be eligible to participate in the Program, an individual shall—

''(1)(A) be accepted for enrollment, or be enrolled, as a full-time or part-time student in a course of study or program (approved by the Secretary) at an accredited graduate school or program of public health; or

''(B) have demonstrated expertise in public health and be accepted for enrollment, or be enrolled, as a full-time or part-time student in a course of study or program (approved by the Secretary) at—

''(i) an accredited graduate school or program of nursing; health administration, management, or policy; preventive medicine; laboratory science; veterinary medicine; or dental medicine; or

''(ii) another accredited graduate school or program, as deemed appropriate by Secretary;

''(2) be eligible for, or hold, an appointment as a commissioned officer in the Regular or Reserve Corps of the Service or be eligible for selection for civilian service in the Corps; and

''(3) sign and submit to the Secretary a written contract (described in subsection (c)) to serve full-time as a public health professional, upon the completion of the course of study or program involved, for the period of obligated service described in subsection (c)(2)(E).

''(c) CONTRACT.—The written contract between the Secretary and an individual under subsection (b)(3) shall contain—

''(1) an agreement on the part of the Secretary that the Secretary will—

''(A) provide the individual with a scholarship for a period of years (not to exceed 4 academic years) during which the individual shall pursue an approved course of study or program to prepare the individual to serve in the public health workforce; and

''(B) accept (subject to the availability of appropriated funds) the individual into the Corps;

''(2) an agreement on the part of the individual that the individual will—

''(A) accept provision of such scholarship to the individual;

''(B) maintain full-time or part-time enrollment in the approved course of study or program described in subsection (b)(1) until the individual completes that course of study or program;

''(C) while enrolled in the approved course of study or program, maintain an acceptable level of academic standing (as determined by the educational institution offering such course of study or program);

''(D) if applicable, complete a residency or internship; and

''(E) serve full-time as a public health professional for a period of time equal to the greater of—

''(i) 1 year for each academic year for which the individual was provided a scholarship under the Program; or

''(ii) 2 years; and

''(3) an agreement by both parties as to the nature and extent of the scholarship assistance, which may include—

''(A) payment of reasonable educational expenses of the individual, including tuition, fees, books, equipment, and laboratory expenses; and

''(B) payment of a stipend of not more than $1,269 (plus, beginning with fiscal year 2011, an amount determined by the Secretary on an annual basis to reflect inflation) per month for each month of the academic year involved, with the dollar amount of such a stipend determined by the Secretary taking into consideration whether the individual is enrolled full-time or part-time.

''(d) APPLICATION OF CERTAIN PROVISIONS.—The provisions of subpart III shall, except as inconsistent with this subpart, apply to the scholarship program under this section in the same manner and to the same extent as such provisions apply to the National Health Service Corps Scholarship Program established under section 338A.

"**SEC. 340N. PUBLIC HEALTH WORKFORCE LOAN REPAYMENT PROGRAM.**

"(a) ESTABLISHMENT.—The Secretary shall establish the Public Health Workforce Loan Repayment Program (referred to in this section as the 'Program') for the purpose described in section 340L(a).

"(b) ELIGIBILITY.—To be eligible to participate in the Program, an individual shall—

"(1)(A) have a graduate degree from an accredited school or program of public health;

"(B) have demonstrated expertise in public health and have a graduate degree in a course of study or program (approved by the Secretary) from—

"(i) an accredited school or program of nursing; health administration, management, or policy; preventive medicine; laboratory science; veterinary medicine; or dental medicine; or

"(ii) another accredited school or program approved by the Secretary; or

"(C) be enrolled as a full-time or part-time student in the final year of a course of study or program (approved by the Secretary) offered by a school or program described in subparagraph (A) or (B), leading to a graduate degree;

''(2) be eligible for, or hold, an appointment as a commissioned officer in the Regular or Reserve Corps of the Service or be eligible for selection for civilian service in the Corps;

''(3) if applicable, complete a residency or internship; and

''(4) sign and submit to the Secretary a written contract (described in subsection (c)) to serve full-time as a public health professional for the period of obligated service described in subsection (c)(2).

''(c) CONTRACT.—The written contract between the Secretary and an individual under subsection (b)(4) shall contain—

''(1) an agreement by the Secretary to repay on behalf of the individual loans incurred by the individual in the pursuit of the relevant public health workforce educational degree in accordance with the terms of the contract;

''(2) an agreement by the individual to serve full-time as a public health professional for a period of time equal to 2 years or such longer period as the individual may agree to; and

''(3) in the case of an individual described in subsection (b)(1)(C) who is in the final year of study and who has accepted employment as a public health

professional, in accordance with subsection 340L(c), an agreement on the part of the individual to complete the education or training, maintain an acceptable level of academic standing (as determined by the educational institution offering the course of study or training), and serve the period of obligated service described in paragraph (2).

''(d) PAYMENTS.—

''(1) IN GENERAL.—A loan repayment provided for an individual under a written contract under the Program shall consist of payment, in accordance with paragraph (2), on behalf of the individual of the principal, interest, and related expenses on government and commercial loans received by the individual regarding the undergraduate or graduate education of the individual (or both), which loans were made for reasonable educational expenses, including tuition, fees, books, equipment, and laboratory expenses, incurred by the individual.

''(2) PAYMENTS FOR YEARS SERVED.—

''(A) IN GENERAL.—For each year of obligated service that an individual contracts to serve under subsection (c), the Secretary may pay up to $35,000 (plus, beginning with fiscal year 2012, an amount determined by the Sec-

retary on an annual basis to reflect inflation) on behalf of the individual for loans described in paragraph (1).

''(B) REPAYMENT SCHEDULE.—Any arrangement made by the Secretary for the making of loan repayments in accordance with this subsection shall provide that any repayments for a year of obligated service shall be made no later than the end of the fiscal year in which the individual completes such year of service.

''(e) APPLICATION OF CERTAIN PROVISIONS.—The provisions of subpart III shall, except as inconsistent with this subpart, apply to the loan repayment program under this section in the same manner and to the same extent as such provisions apply to the National Health Service Corps Loan Repayment Program established under section 338B.''.

SEC. 2232. ENHANCING THE PUBLIC HEALTH WORKFORCE.

Section 765 (42 U.S.C. 295) is amended to read as follows:

''**SEC. 765. ENHANCING THE PUBLIC HEALTH WORKFORCE.**

''(a) PROGRAM.—The Secretary, acting through the Administrator of the Health Resources and Services Administration and in consultation with the Director of the Centers for Disease Control and Prevention, shall estab-

lish a public health workforce training and enhancement program consisting of awarding grants and contracts under subsection (b).

''(b) GRANTS AND CONTRACTS.—The Secretary shall award grants and contracts to eligible entities—

''(1) to plan, develop, operate, or participate in, an accredited professional training program in the field of public health (including such a program in nursing; health administration, management, or policy; preventive medicine; laboratory science; veterinary medicine; or dental medicine) for members of the public health workforce including mid-career professionals;

''(2) to provide financial assistance in the form of traineeships and fellowships to students who are participants in any such program and who plan to specialize or work in the field of public health;

''(3) to plan, develop, operate, or participate in a program for the training of public health professionals who plan to teach in any program described in paragraph (1); and

''(4) to provide financial assistance in the form of traineeships and fellowships to public health professionals who are participants in any program described in paragraph (1) and who plan to teach in

the field of public health, including nursing; health administration, management, or policy; preventive medicine; laboratory science; veterinary medicine; or dental medicine.

''(c) ELIGIBILITY.—To be eligible for a grant or contract under subsection (a), an entity shall be—

''(1) an accredited health professions school, including an accredited graduate school or program of public health; nursing; health administration, management, or policy; preventive medicine; laboratory science; veterinary medicine; or dental medicine;

''(2) a State, local, or tribal health department;

''(3) a public or private nonprofit entity; or

''(4) a consortium of 2 or more entities described in paragraphs (1) through (3).

''(d) PREFERENCE.—In awarding grants or contracts under this section, the Secretary shall give preference to entities that have a demonstrated record of the following:

''(1) Training the greatest percentage, or significantly improving the percentage, of public health professionals who serve in underserved communities.

''(2) Training individuals who are from underrepresented minority groups or disadvantaged backgrounds.

''(3) Training individuals in public health specialties experiencing a significant shortage of public health professionals (as determined by the Secretary).

''(4) Training the greatest percentage, or significantly improving the percentage, of public health professionals serving in the Federal Government or a State, local, or tribal government.

''(e) REPORT.—The Secretary shall submit to the Congress an annual report on the program carried out under this section.''.

SEC. 2233. PUBLIC HEALTH TRAINING CENTERS.

Section 766 (42 U.S.C. 295a) is amended—

(1) in subsection (b)(1), by striking ''in furtherance of the goals established by the Secretary for the year 2000'' and inserting ''in furtherance of the goals established by the Secretary in the national prevention and wellness strategy under section 3121''; and

(2) by adding at the end the following:

''(d) REPORT.—The Secretary shall submit to the Congress an annual report on the program carried out under this section.''.

SEC. 2234. PREVENTIVE MEDICINE AND PUBLIC HEALTH TRAINING GRANT PROGRAM.

Section 768 (42 U.S.C. 295c) is amended to read as follows:

"**SEC. 768. PREVENTIVE MEDICINE AND PUBLIC HEALTH TRAINING GRANT PROGRAM.**

''(a) GRANTS.—The Secretary, acting through the Administrator of the Health Resources and Services Administration and in consultation with the Director of the Centers for Disease Control and Prevention, shall award grants to, or enter into contracts with, eligible entities to provide training to graduate medical residents in preventive medicine specialties.

''(b) ELIGIBILITY.—To be eligible for a grant or contract under subsection (a), an entity shall be—

''(1) an accredited school of public health or school of medicine or osteopathic medicine;

''(2) an accredited public or private hospital;

''(3) a State, local, or tribal health department; or

''(4) a consortium of 2 or more entities described in paragraphs (1) through (3).

''(c) USE OF FUNDS.—Amounts received under a grant or contract under this section shall be used to—

''(1) plan, develop (including the development of curricula), operate, or participate in an accredited

residency or internship program in preventive medicine or public health;

''(2) defray the costs of practicum experiences, as required in such a program; and

''(3) establish, maintain, or improve—

''(A) academic administrative units (including departments, divisions, or other appropriate units) in preventive medicine and public health; or

''(B) programs that improve clinical teaching in preventive medicine and public health.

''(d) REPORT.—The Secretary shall submit to the Congress an annual report on the program carried out under this section.''.

SEC. 2235. AUTHORIZATION OF APPROPRIATIONS.

(a) IN GENERAL.—Section 799C, as added by section 2216 of this Act, is amended by adding at the end the following:

''(b) PUBLIC HEALTH WORKFORCE.—For the purpose of carrying out subpart XII of part D of title III and sections 765, 766, and 768, in addition to any other amounts authorized to be appropriated for such purpose, there are authorized to be appropriated, out of any monies in the Public Health Investment Fund, the following:

''(1) $51,000,000 for fiscal year 2010.

''(2) $54,000,000 for fiscal year 2011.

''(3) $57,000,000 for fiscal year 2012.

''(4) $59,000,000 for fiscal year 2013.

''(5) $62,000,000 for fiscal year 2014.

''(6) $65,000,000 for fiscal year 2015.

''(7) $68,000,000 for fiscal year 2016.

''(8) $72,000,000 for fiscal year 2017.

''(9) $75,000,000 for fiscal year 2018.

''(10) $79,000,000 for fiscal year 2019.''.

(b) EXISTING AUTHORIZATION OF APPROPRIATIONS.—Subpart (a) of section 770 (42 U.S.C. 295e) is amended by striking ''2002'' and inserting ''2019''.

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.

Paragraph (1) of section 738(a) (42 U.S.C. 293b(a)) is amended by striking ''not more than $20,000'' and all that follows through the end of the paragraph and insert-

ing: ''not more than $35,000 (plus, beginning with fiscal year 2012, an amount determined by the Secretary on an annual basis to reflect inflation) of the principal and interest of the educational loans of such individuals.''.

SEC. 2242. NURSING WORKFORCE DIVERSITY GRANTS.

Subsection (b) of section 821 (42 U.S.C. 296m) is amended—

(1) in the heading, by striking ''GUIDANCE'' and inserting ''CONSULTATION''; and

(2) by striking ''shall take into consideration'' and all that follows through ''consult with nursing associations'' and inserting ''shall, as appropriate, consult with nursing associations''.

SEC. 2243. COORDINATION OF DIVERSITY AND CULTURAL COMPETENCY PROGRAMS.

Title VII (42 U.S.C. 292 et seq.) is amended by inserting after section 739 the following:

''**SEC. 739A. COORDINATION OF DIVERSITY AND CULTURAL COMPETENCY PROGRAMS.**

''The Secretary shall, to the extent practicable, coordinate the activities carried out under this part and section 821 in order to enhance the effectiveness of such activities and avoid duplication of effort.''.

PART 2—INTERDISCIPLINARY TRAINING PROGRAMS

SEC. 2251. CULTURAL AND LINGUISTIC COMPETENCY TRAINING FOR HEALTH CARE PROFESSIONALS.

Section 741 (42 U.S.C. 293e) is amended—

(1) in the section heading, by striking ''GRANTS FOR HEALTH PROFESSIONS EDUCATION'' and inserting ''CULTURAL AND LINGUISTIC COMPETENCY TRAINING FOR HEALTH CARE PROFESSIONALS'';

(2) by redesignating subsection (b) as subsection (h); and

(3) by striking subsection (a) and inserting the following:

''(a) PROGRAM.—The Secretary shall establish a cultural and linguistic competency training program for health care professionals, including nurse professionals, consisting of awarding grants and contracts under subsection (b).

''(b) CULTURAL AND LINGUISTIC COMPETENCY TRAINING.—The Secretary shall award grants and contracts to eligible entities—

''(1) to test, develop, and evaluate models of cultural and linguistic competency training (including continuing education) for health professionals; and

''(2) to implement cultural and linguistic competency training programs for health professionals developed under paragraph (1) or otherwise.

''(c) ELIGIBILITY.—To be eligible for a grant or contract under subsection (b), an entity shall be—

''(1) an accredited health professions school or program;

''(2) an academic health center;

''(3) a public or private nonprofit entity; or

''(4) a consortium of 2 or more entities described in paragraphs (1) through (3).

''(d) PREFERENCE.—In awarding grants and contracts under this section, the Secretary shall give preference to entities that have a demonstrated record of the following:

''(1) Addressing, or partnering with an entity with experience addressing, the cultural and linguistic competency needs of the population to be served through the grant or contract.

''(2) Addressing health disparities.

''(3) Placing health professionals in regions experiencing significant changes in the cultural and linguistic demographics of populations, including communities along the United States-Mexico border.

''(4) Carrying out activities described in subsection (b) with respect to more than one health profession discipline, specialty, or subspecialty.

''(e) CONSULTATION.—The Secretary shall carry out this section in consultation with the heads of appropriate health agencies and offices in the Department of Health and Human Services, including the Office of Minority Health.

''(f) DEFINITION.—In this section, the term 'health disparities' has the meaning given to the term in section 3171.

''(g) REPORT.—The Secretary shall submit to the Congress an annual report on the program carried out under this section.''.

SEC. 2252. INNOVATIONS IN INTERDISCIPLINARY CARE TRAINING.

Part D of title VII (42 U.S.C. 294 et seq.) is amended by adding at the end the following:

''**SEC. 759. INNOVATIONS IN INTERDISCIPLINARY CARE TRAINING.**

''(a) PROGRAM.—The Secretary shall establish an innovations in interdisciplinary care training program consisting of awarding grants and contracts under subsection (b).

''(b) TRAINING PROGRAMS.—The Secretary shall award grants to, or enter into contracts with, eligible entities—

''(1) to test, develop, and evaluate health professional training programs (including continuing education) designed to promote—

''(A) the delivery of health services through interdisciplinary and team-based models, which may include patient-centered medical home models, medication therapy management models, and models integrating physical, mental, or oral health services; and

''(B) coordination of the delivery of health care within and across settings, including health care institutions, community-based settings, and the patient's home; and

''(2) to implement such training programs developed under paragraph (1) or otherwise.

''(c) ELIGIBILITY.—To be eligible for a grant or contract under subsection (b), an entity shall be—

''(1) an accredited health professions school or program;

''(2) an academic health center;

''(3) a public or private nonprofit entity (including an area health education center or a geriatric education center); or

''(4) a consortium of 2 or more entities described in paragraphs (1) through (3).

''(d) PREFERENCES.—In awarding grants and contracts under this section, the Secretary shall give preference to entities that have a demonstrated record of the following:

''(1) Training the greatest percentage, or significantly increasing the percentage, of health professionals who serve in underserved communities.

''(2) Broad interdisciplinary team-based collaborations.

''(3) Addressing health disparities.

''(e) REPORT.—The Secretary shall submit to the Congress an annual report on the program carried out under this section.

''(f) DEFINITIONS.—In this section:

''(1) The term 'health disparities' has the meaning given the term in section 3171.

''(2) The term 'interdisciplinary' means collaboration across health professions and specialties, which may include public health, nursing, allied health, and appropriate medical specialties.''.

PART 3—ADVISORY COMMITTEE ON HEALTH WORKFORCE EVALUATION AND ASSESSMENT

SEC. 2261. HEALTH WORKFORCE EVALUATION AND ASSESSMENT.

Subpart 1 of part E of title VII (42 U.S.C. 294n et seq.) is amended by adding at the end the following:

"**SEC. 764. HEALTH WORKFORCE EVALUATION AND ASSESSMENT.**

''(a) ADVISORY COMMITTEE.—The Secretary, acting through the Assistant Secretary for Health, shall establish a permanent advisory committee to be known as the Advisory Committee on Health Workforce Evaluation and Assessment (referred to in this section as the 'Advisory Committee').

''(b) RESPONSIBILITIES.—The Advisory Committee shall—

''(1) not later than 1 year after the date of the establishment of the Advisory Committee, submit recommendations to the Secretary on—

''(A) classifications of the health workforce to ensure consistency of data collection on the health workforce; and

''(B) based on such classifications, standardized methodologies and procedures to enumerate the health workforce;

''(2) not later than 2 years after the date of the establishment of the Advisory Committee, submit recommendations to the Secretary on—

''(A) the supply, diversity, and geographic distribution of the health workforce;

''(B) the retention of the health workforce to ensure quality and adequacy of such workforce; and

''(C) policies to carry out the recommendations made pursuant to subparagraphs (A) and (B); and

''(3) not later than 4 years after the date of the establishment of the Advisory Committee, and every 2 years thereafter, submit updated recommendations to the Secretary under paragraphs (1) and (2).

''(c) ROLE OF AGENCY.—The Secretary shall provide ongoing administrative, research, and technical support for the operations of the Advisory Committee, including coordinating and supporting the dissemination of the recommendations of the Advisory Committee.

''(d) MEMBERSHIP.—

''(1) NUMBER; APPOINTMENT.—The Secretary shall appoint 15 members to serve on the Advisory Committee.

''(2) TERMS.—

''(A) IN GENERAL.—The Secretary shall appoint members of the Advisory Committee for a term of 3 years and may reappoint such members, but the Secretary may not appoint any member to serve more than a total of 6 years.

''(B) STAGGERED TERMS.—Notwithstanding subparagraph (A), of the members first appointed to the Advisory Committee under paragraph (1)—

''(i) 5 shall be appointed for a term of 1 year;

''(ii) 5 shall be appointed for a term of 2 years; and

''(iii) 5 shall be appointed for a term of 3 years.

''(3) QUALIFICATIONS.—Members of the Advisory Committee shall be appointed from among individuals who possess expertise in at least one of the following areas:

''(A) Conducting and interpreting health workforce market analysis, including health care labor workforce analysis.

''(B) Conducting and interpreting health finance and economics research.

''(C) Delivering and administering health care services.

''(D) Delivering and administering health workforce education and training.

''(4) REPRESENTATION.—In appointing members of the Advisory Committee, the Secretary shall—

''(A) include no less than one representative of each of—

''(i) health professionals within the health workforce;

''(ii) health care patients and consumers;

''(iii) employers;

''(iv) labor unions; and

''(v) third-party health payors; and

''(B) ensure that—

''(i) all areas of expertise described in paragraph (3) are represented;

''(ii) the members of the Advisory Committee include members who, collectively, have significant experience working with—

''(I) populations in urban and federally designated rural and non-metropolitan areas; and

''(II) populations who are underrepresented in the health professions, including underrepresented minority groups; and

''(iii) individuals who are directly involved in health professions education or practice do not constitute a majority of the members of the Advisory Committee.

''(5) DISCLOSURE AND CONFLICTS OF INTEREST.—Members of the Advisory Committee shall not be considered employees of the Federal Government by reason of service on the Advisory Committee, except members of the Advisory Committee shall be considered to be special Government employees within the meaning of section 107 of the Ethics in Government Act of 1978 (5 U.S.C. App.) and section 208 of title 18, United States Code, for the purposes of disclosure and management of conflicts of interest under those sections.

''(6) NO PAY; RECEIPT OF TRAVEL EXPENSES.—Members of the Advisory Committee shall not receive any pay for service on the Committee,

but may receive travel expenses, including a per diem, in accordance with applicable provisions of subchapter I of chapter 57 of title 5, United States Code.

''(e) CONSULTATION.—In carrying out this section, the Secretary shall consult with the Secretary of Education and the Secretary of Labor.

''(f) COLLABORATION.—The Advisory Committee shall collaborate with the advisory bodies at the Health Resources and Services Administration, the National Advisory Council (as authorized in section 337), the Advisory Committee on Training in Primary Care Medicine and Dentistry (as authorized in section 749A), the Advisory Committee on Interdisciplinary, Community-Based Linkages (as authorized in section 756), the Advisory Council on Graduate Medical Education (as authorized in section 762), and the National Advisory Council on Nurse Education and Practice (as authorized in section 851).

''(g) FACA.—The Federal Advisory Committee Act (5 U.S.C. App.) except for section 14 of such Act shall apply to the Advisory Committee under this section only to the extent that the provisions of such Act do not conflict with the requirements of this section.

''(h) REPORT.—The Secretary shall submit to the Congress an annual report on the activities of the Advisory Committee.

''(i) DEFINITION.—In this section, the term 'health workforce' includes all health care providers with direct patient care and support responsibilities, including physicians, nurses, physician assistants, pharmacists, oral health professionals (as defined in section 749(f)), allied health professionals, mental and behavioral professionals, and public health professionals (including veterinarians engaged in public health practice).''.

PART 4—HEALTH WORKFORCE ASSESSMENT

SEC. 2271. HEALTH WORKFORCE ASSESSMENT.

(a) IN GENERAL.—Section 761 (42 U.S.C. 294n) is amended—

(1) by redesignating subsection (c) as subsection (e); and

(2) by striking subsections (a) and (b) and inserting the following:

''(a) IN GENERAL.—The Secretary shall, based upon the classifications and standardized methodologies and procedures developed by the Advisory Committee on Health Workforce Evaluation and Assessment under section 764(b)—

''(1) collect data on the health workforce (as defined in section 764(i)), disaggregated by field, discipline, and specialty, with respect to—

''(A) the supply (including retention) of health professionals relative to the demand for such professionals;

''(B) the diversity of health professionals (including with respect to race, ethnic background, and gender); and

''(C) the geographic distribution of health professionals; and

''(2) collect such data on individuals participating in the programs authorized by subtitles A, B, and C and part 1 of subtitle D of title II of division C of the America's Affordable Health Choices Act of 2009.

''(b) GRANTS AND CONTRACTS FOR HEALTH WORKFORCE ANALYSIS.—

''(1) IN GENERAL.—The Secretary may award grants or contracts to eligible entities to carry out subsection (a).

''(2) ELIGIBILITY.—To be eligible for a grant or contract under this subsection, an entity shall be—

''(A) an accredited health professions school or program;

''(B) an academic health center;

''(C) a State, local, or tribal government;

''(D) a public or private entity; or

''(E) a consortium of 2 or more entities described in subparagraphs (A) through (D).

''(c) COLLABORATION AND DATA SHARING.—The Secretary shall collaborate with Federal departments and agencies, health professions organizations (including health professions education organizations), and professional medical societies for the purpose of carrying out subsection (a).

''(d) REPORT.—The Secretary shall submit to the Congress an annual report on the data collected under subsection (a).''.

(b) PERIOD BEFORE COMPLETION OF NATIONAL STRATEGY.—Pending completion of the classifications and standardized methodologies and procedures developed by the Advisory Committee on Health Workforce Evaluation and Assessment under section 764(b) of the Public Health Service Act, as added by section 2261, the Secretary of Health and Human Services, acting through the Administrator of the Health Resources and Services Administration and in consultation with such Advisory Committee,

may make a judgment about the classifications, methodologies, and procedures to be used for collection of data under section 761(a) of the Public Health Service Act, as amended by this section.

PART 5—AUTHORIZATION OF APPROPRIATIONS

SEC. 2281. AUTHORIZATION OF APPROPRIATIONS.

(a) IN GENERAL.—Section 799C, as added by section 2216 of this Act, is amended by adding at the end the following:

''(c) HEALTH PROFESSIONS TRAINING FOR DIVERSITY.—For the purpose of carrying out sections 736, 737, 738, 739, and 739A, in addition to any other amounts authorized to be appropriated for such purpose, there are authorized to be appropriated, out of any monies in the Public Health Investment Fund, the following:

''(1) $90,000,000 for fiscal year 2010.

''(2) $97,000,000 for fiscal year 2011.

''(3) $100,000,000 for fiscal year 2012.

''(4) $104,000,000 for fiscal year 2013.

''(5) $110,000,000 for fiscal year 2014.

''(6) $116,000,000 for fiscal year 2015.

''(7) $121,000,000 for fiscal year 2016.

''(8) $127,000,000 for fiscal year 2017.

''(9) $133,000,000 for fiscal year 2018.

''(10) $140,000,000 for fiscal year 2019.

''(d) INTERDISCIPLINARY TRAINING PROGRAMS, ADVISORY COMMITTEE ON HEALTH WORKFORCE EVALUATION AND ASSESSMENT, AND HEALTH WORKFORCE ASSESSMENT.—For the purpose of carrying out sections 741, 759, 761, and 764, in addition to any other amounts authorized to be appropriated for such purpose, there are authorized to be appropriated, out of any monies in the Public Health Investment Fund, the following:

''(1) $91,000,000 for fiscal year 2010.

''(2) $97,000,000 for fiscal year 2011.

''(3) $101,000,000 for fiscal year 2012.

''(4) $105,000,000 for fiscal year 2013.

''(5) $111,000,000 for fiscal year 2014.

''(6) $117,000,000 for fiscal year 2015.

''(7) $122,000,000 for fiscal year 2016.

''(8) $129,000,000 for fiscal year 2017.

''(9) $135,000,000 for fiscal year 2018.

''(10) $141,000,000 for fiscal year 2019.''.

(b) EXISTING AUTHORIZATIONS OF APPROPRIATIONS.—

(1) SECTION 736.—Paragraph (1) of section 736(h) (42 U.S.C. 293(h)) is amended by striking ''2002'' and inserting ''2019''.

(2) SECTIONS 737, 738, AND 739.—Subsections (a), (b), and (c) of section 740 are amended by

striking ''2002'' each place it appears and inserting ''2019''.

(3) SECTION 741.—Subsection (h), as so redesignated, of section 741 is amended—

(A) by striking ''and'' after ''fiscal year 2003,''; and

(B) by inserting '', and such sums as may be necessary for subsequent fiscal years through the end of fiscal year 2019'' before the period at the end.

(4) SECTION 761.—Subsection (e)(1), as so redesignated, of section 761 is amended by striking ''2002'' and inserting ''2019''.

TITLE III—PREVENTION AND WELLNESS

SEC. 2301. PREVENTION AND WELLNESS.

(a) IN GENERAL.—The Public Health Service Act (42 U.S.C. 201 et seq.) is amended by adding at the end the following:

''TITLE XXXI—PREVENTION AND WELLNESS

''Subtitle A—Prevention and Wellness Trust

''SEC. 3111. PREVENTION AND WELLNESS TRUST.

''(a) DEPOSITS INTO TRUST.—There is established a Prevention and Wellness Trust. There are authorized to be appropriated to the Trust—

''(1) amounts described in section 2002(b)(2)(ii) of the America's Affordable Health Choices Act of 2009 for each fiscal year; and

''(2) in addition, out of any monies in the Public Health Investment Fund—

''(A) for fiscal year 2010, $2,400,000,000;

''(B) for fiscal year 2011, $2,800,000,000;

''(C) for fiscal year 2012, $3,100,000,000;

''(D) for fiscal year 2013, $3,400,000,000;

''(E) for fiscal year 2014, $3,500,000,000;

''(F) for fiscal year 2015, $3,600,000,000;

''(G) for fiscal year 2016, $3,700,000,000;

''(H) for fiscal year 2017, $3,900,000,000;

''(I) for fiscal year 2018, $4,300,000,000; and

''(J) for fiscal year 2019, $4,600,000,000.

''(b) AVAILABILITY OF FUNDS.—Amounts in the Prevention and Wellness Trust shall be available, as provided in advance in appropriation Acts, for carrying out this title.

''(c) ALLOCATION.—Of the amounts authorized to be appropriated in subsection (a)(2), there are authorized to be appropriated—

''(1) for carrying out subtitle C (Prevention Task Forces), $35,000,000 for each of fiscal years 2010 through 2019;

''(2) for carrying out subtitle D (Prevention and Wellness Research)—

''(A) for fiscal year 2010, $100,000,000;

''(B) for fiscal year 2011, $150,000,000;

''(C) for fiscal year 2012, $200,000,000;

''(D) for fiscal year 2013, $250,000,000;

''(E) for fiscal year 2014, $300,000,000;

''(F) for fiscal year 2015, $315,000,000;

''(G) for fiscal year 2016, $331,000,000;

''(H) for fiscal year 2017, $347,000,000;

''(I) for fiscal year 2018, $364,000,000; and

''(J) for fiscal year 2019, $383,000,000.

''(3) for carrying out subtitle E (Delivery of Community Preventive and Wellness Services)—

''(A) for fiscal year 2010, $1,100,000,000;

''(B) for fiscal year 2011, $1,300,000,000;

''(C) for fiscal year 2012, $1,400,000,000;

''(D) for fiscal year 2013, $1,600,000,000;

''(E) for fiscal year 2014, $1,700,000,000;

''(F) for fiscal year 2015, $1,800,000,000;

''(G) for fiscal year 2016, $1,900,000,000;

''(H) for fiscal year 2017, $2,000,000,000;

''(I) for fiscal year 2018, $2,100,000,000; and

''(J) for fiscal year 2019, $2,300,000,000.

''(4) for carrying out section 3161 (Core Public Health Infrastructure and Activities for State and Local Health Departments)—

''(A) for fiscal year 2010, $800,000,000;

''(B) for fiscal year 2011, $1,000,000,000;

''(C) for fiscal year 2012, $1,100,000,000;

''(D) for fiscal year 2013, $1,200,000,000;

''(E) for fiscal year 2014, $1,300,000,000;

''(F) for fiscal year 2015, $1,400,000,000;

''(G) for fiscal year 2016, $1,500,000,000;

''(H) for fiscal year 2017, $1,600,000,000;

''(I) for fiscal year 2018, $1,800,000,000; and

''(J) for fiscal year 2019, $1,900,000,000; and

''(5) for carrying out section 3162 (Core Public Health Infrastructure and Activities for CDC), $400,000,000 for each of fiscal years 2010 through 2019.

''Subtitle B—National Prevention and Wellness Strategy

''SEC. 3121. NATIONAL PREVENTION AND WELLNESS STRATEGY.

''(a) IN GENERAL.—The Secretary shall submit to the Congress within one year after the date of the enactment of this section, and at least every 2 years thereafter, a national strategy that is designed to improve the Nation's health through evidence-based clinical and community prevention and wellness activities (in this section referred to as 'prevention and wellness activities'), including core public health infrastructure improvement activities.

''(b) CONTENTS.—The strategy under subsection (a) shall include each of the following:

''(1) Identification of specific national goals and objectives in prevention and wellness activities that take into account appropriate public health measures and standards, including departmental measures and

standards (including Healthy People and National Public Health Performance Standards).

''(2) Establishment of national priorities for prevention and wellness, taking into account unmet prevention and wellness needs.

''(3) Establishment of national priorities for research on prevention and wellness, taking into account unanswered research questions on prevention and wellness.

''(4) Identification of health disparities in prevention and wellness.

''(5) A plan for addressing and implementing paragraphs (1) through (4).

''(c) CONSULTATION.—In developing or revising the strategy under subsection (a), the Secretary shall consult with the following:

''(1) The heads of appropriate health agencies and offices in the Department, including the Office of the Surgeon General of the Public Health Service, the Office of Minority Health, and the Office on Women's Health.

''(2) As appropriate, the heads of other Federal departments and agencies whose programs have a significant impact upon health (as determined by the Secretary).

''(3) As appropriate, nonprofit and for-profit entities.

''(4) The Association of State and Territorial Health Officials and the National Association of County and City Health Officials.

''Subtitle C—Prevention Task Forces

''SEC. 3131. TASK FORCE ON CLINICAL PREVENTIVE SERVICES.

''(a) IN GENERAL.—The Secretary, acting through the Director of the Agency for Healthcare Research and Quality, shall establish a permanent task force to be known as the Task Force on Clinical Preventive Services (in this section referred to as the 'Task Force').

''(b) RESPONSIBILITIES.—The Task Force shall—

''(1) identify clinical preventive services for review;

''(2) review the scientific evidence related to the benefits, effectiveness, appropriateness, and costs of clinical preventive services identified under paragraph (1) for the purpose of developing, updating, publishing, and disseminating evidence-based recommendations on the use of such services;

''(3) as appropriate, take into account health disparities in developing, updating, publishing, and

disseminating evidence-based recommendations on the use of such services;

''(4) identify gaps in clinical preventive services research and evaluation and recommend priority areas for such research and evaluation;

''(5) as appropriate, consult with the clinical prevention stakeholders board in accordance with subsection (f);

''(6) as appropriate, consult with the Task Force on Community Preventive Services established under section 3132; and

''(7) as appropriate, in carrying out this section, consider the national strategy under section 3121.

''(c) ROLE OF AGENCY.—The Secretary shall provide ongoing administrative, research, and technical support for the operations of the Task Force, including coordinating and supporting the dissemination of the recommendations of the Task Force.

''(d) MEMBERSHIP.—

''(1) NUMBER; APPOINTMENT.—The Task Force shall be composed of 30 members, appointed by the Secretary.

''(2) TERMS.—

''(A) IN GENERAL.—The Secretary shall appoint members of the Task Force for a term of 6 years and may reappoint such members, but the Secretary may not appoint any member to serve more than a total of 12 years.

''(B) STAGGERED TERMS.—Notwithstanding subparagraph (A), of the members first appointed to serve on the Task Force after the enactment of this title—

''(i) 10 shall be appointed for a term of 2 years;

''(ii) 10 shall be appointed for a term of 4 years; and

''(iii) 10 shall be appointed for a term of 6 years.

''(3) QUALIFICATIONS.—Members of the Task Force shall be appointed from among individuals who possess expertise in at least one of the following areas:

''(A) Health promotion and disease prevention.

''(B) Evaluation of research and systematic evidence reviews.

''(C) Application of systematic evidence reviews to clinical decisionmaking or health policy.

''(D) Clinical primary care in child and adolescent health.

''(E) Clinical primary care in adult health, including women's health.

''(F) Clinical primary care in geriatrics.

''(G) Clinical counseling and behavioral services for primary care patients.

''(4) REPRESENTATION.—In appointing members of the Task Force, the Secretary shall ensure that—

''(A) all areas of expertise described in paragraph (3) are represented; and

''(B) the members of the Task Force include practitioners who, collectively, have significant experience treating racially and ethnically diverse populations.

''(e) SUBGROUPS.—As appropriate to maximize efficiency, the Task Force may delegate authority for conducting reviews and making recommendations to subgroups consisting of Task Force members, subject to final approval by the Task Force.

''(f) CLINICAL PREVENTION STAKEHOLDERS BOARD.—

''(1) IN GENERAL.—The Task Force shall convene a clinical prevention stakeholders board composed of representatives of appropriate public and private entities with an interest in clinical preventive services to advise the Task Force on developing, updating, publishing, and disseminating evidence-based recommendations on the use of clinical preventive services.

''(2) MEMBERSHIP.—The members of the clinical prevention stakeholders board shall include representatives of the following:

''(A) Health care consumers and patient groups.

''(B) Providers of clinical preventive services, including community-based providers.

''(C) Federal departments and agencies, including—

''(i) appropriate health agencies and offices in the Department, including the Office of the Surgeon General of the Public Health Service, the Office of Minority Health, and the Office on Women's Health; and

''(ii) as appropriate, other Federal departments and agencies whose programs have a significant impact upon health (as determined by the Secretary).

''(D) Private health care payors.

''(3) RESPONSIBILITIES.—In accordance with subsection (b)(5), the clinical prevention stakeholders board shall—

''(A) recommend clinical preventive services for review by the Task Force;

''(B) suggest scientific evidence for consideration by the Task Force related to reviews undertaken by the Task Force;

''(C) provide feedback regarding draft recommendations by the Task Force; and

''(D) assist with efforts regarding dissemination of recommendations by the Director of the Agency for Healthcare Research and Quality.

''(g) DISCLOSURE AND CONFLICTS OF INTEREST.—Members of the Task Force or the clinical prevention stakeholders board shall not be considered employees of the Federal Government by reason of service on the Task Force, except members of the Task Force shall be considered to be special Government employees within the mean-

ing of section 107 of the Ethics in Government Act of 1978 (5 U.S.C. App.) and section 208 of title 18, United States Code, for the purposes of disclosure and management of conflicts of interest under those sections.

''(h) NO PAY; RECEIPT OF TRAVEL EXPENSES.—Members of the Task Force or the clinical prevention stakeholders board shall not receive any pay for service on the Task Force, but may receive travel expenses, including a per diem, in accordance with applicable provisions of subchapter I of chapter 57 of title 5, United States Code.

''(i) APPLICATION OF FACA.—The Federal Advisory Committee Act (5 U.S.C. App.) except for section 14 of such Act shall apply to the Task Force to the extent that the provisions of such Act do not conflict with the provisions of this title.

''(j) REPORT.—The Secretary shall submit to the Congress an annual report on the Task Force, including with respect to gaps identified and recommendations made under subsection (b)(4).

''**SEC. 3132. TASK FORCE ON COMMUNITY PREVENTIVE SERVICES.**

''(a) IN GENERAL.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall establish a permanent task force to be

known as the Task Force on Community Preventive Services (in this section referred to as the 'Task Force').

''(b) RESPONSIBILITIES.—The Task Force shall—

''(1) identify community preventive services for review;

''(2) review the scientific evidence related to the benefits, effectiveness, appropriateness, and costs of community preventive services identified under paragraph (1) for the purpose of developing, updating, publishing, and disseminating evidence-based recommendations on the use of such services;

''(3) as appropriate, take into account health disparities in developing, updating, publishing, and disseminating evidence-based recommendations on the use of such services;

''(4) identify gaps in community preventive services research and evaluation and recommend priority areas for such research and evaluation;

''(5) as appropriate, consult with the community prevention stakeholders board in accordance with subsection (f);

''(6) as appropriate, consult with the Task Force on Clinical Preventive Services established under section 3131; and

''(7) as appropriate, in carrying out this section, consider the national strategy under section 3121.

''(c) ROLE OF AGENCY.—The Secretary shall provide ongoing administrative, research, and technical support for the operations of the Task Force, including coordinating and supporting the dissemination of the recommendations of the Task Force.

''(d) MEMBERSHIP.—

''(1) NUMBER; APPOINTMENT.—The Task Force shall be composed of 30 members, appointed by the Secretary.

''(2) TERMS.—

''(A) IN GENERAL.—The Secretary shall appoint members of the Task Force for a term of 6 years and may reappoint such members, but the Secretary may not appoint any member to serve more than a total of 12 years.

''(B) STAGGERED TERMS.—Notwithstanding subparagraph (A), of the members first appointed to serve on the Task Force after the enactment of this section—

''(i) 10 shall be appointed for a term of 2 years;

''(ii) 10 shall be appointed for a term of 4 years; and

''(iii) 10 shall be appointed for a term of 6 years.

''(3) QUALIFICATIONS.—Members of the Task Force shall be appointed from among individuals who possess expertise in at least one of the following areas:

''(A) Public health.

''(B) Evaluation of research and systematic evidence reviews.

''(C) Disciplines relevant to community preventive services, including health promotion; disease prevention; chronic disease; worksite health; qualitative and quantitative analysis; and health economics, policy, law, and statistics.

''(4) REPRESENTATION.—In appointing members of the Task Force, the Secretary—

''(A) shall ensure that all areas of expertise described in paragraph (3) are represented;

''(B) shall ensure that such members include sufficient representatives of each of—

''(i) State health officers;

''(ii) local health officers;

''(iii) health care practitioners; and

''(iv) public health practitioners; and

''(C) shall appoint individuals who, collectively, have significant experience working with racially and ethnically diverse populations.

''(e) SUBGROUPS.—As appropriate to maximize efficiency, the Task Force may delegate authority for conducting reviews and making recommendations to subgroups consisting of Task Force members, subject to final approval by the Task Force.

''(f) COMMUNITY PREVENTION STAKEHOLDERS BOARD.—

''(1) IN GENERAL.—The Task Force shall convene a community prevention stakeholders board composed of representatives of appropriate public and private entities with an interest in community preventive services to advise the Task Force on developing, updating, publishing, and disseminating evidence-based recommendations on the use of community preventive services.

''(2) MEMBERSHIP.—The members of the community prevention stakeholders board shall include representatives of the following:

''(A) Health care consumers and patient groups.

''(B) Providers of community preventive services, including community-based providers.

''(C) Federal departments and agencies, including—

''(i) appropriate health agencies and offices in the Department, including the Office of the Surgeon General of the Public Health Service, the Office of Minority Health, and the Office on Women's Health; and

''(ii) as appropriate, other Federal departments and agencies whose programs have a significant impact upon health (as determined by the Secretary).

''(D) Private health care payors.

''(3) RESPONSIBILITIES.—In accordance with subsection (b)(5), the community prevention stakeholders board shall—

''(A) recommend community preventive services for review by the Task Force;

''(B) suggest scientific evidence for consideration by the Task Force related to reviews undertaken by the Task Force;

''(C) provide feedback regarding draft recommendations by the Task Force; and

''(D) assist with efforts regarding dissemination of recommendations by the Director of the Centers for Disease Control and Prevention.

''(g) DISCLOSURE AND CONFLICTS OF INTEREST.—Members of the Task Force or the community prevention stakeholders board shall not be considered employees of the Federal Government by reason of service on the Task Force, except members of the Task Force shall be considered to be special Government employees within the meaning of section 107 of the Ethics in Government Act of 1978 (5 U.S.C. App.) and section 208 of title 18, United States Code, for the purposes of disclosure and management of conflicts of interest under those sections.

''(h) NO PAY; RECEIPT OF TRAVEL EXPENSES.—Members of the Task Force or the community prevention stakeholders board shall not receive any pay for service on the Task Force, but may receive travel expenses, including a per diem, in accordance with applicable provisions of subchapter I of chapter 57 of title 5, United States Code.

''(i) APPLICATION OF FACA.—The Federal Advisory Committee Act (5 U.S.C. App.) except for section 14 of such Act shall apply to the Task Force to the extent that the provisions of such Act do not conflict with the provisions of this title.

''(j) REPORT.—The Secretary shall submit to the Congress an annual report on the Task Force, including with respect to gaps identified and recommendations made under subsection (b)(4).

''Subtitle D—Prevention and Wellness Research

''SEC. 3141. PREVENTION AND WELLNESS RESEARCH ACTIVITY COORDINATION.

''In conducting or supporting research on prevention and wellness, the Director of the Centers for Disease Control and Prevention, the Director of the National Institutes of Health, and the heads of other agencies within the Department of Health and Human Services conducting or supporting such research, shall take into consideration the national strategy under section 3121 and the recommendations of the Task Force on Clinical Preventive Services under section 3131 and the Task Force on Community Preventive Services under section 3132.

''SEC. 3142. COMMUNITY PREVENTION AND WELLNESS RESEARCH GRANTS.

''(a) IN GENERAL.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall conduct, or award grants to eligible entities to conduct, research in priority areas identified by the Secretary in the national strategy under section 3121 or by

the Task Force on Community Preventive Services as required by section 3132.

''(b) ELIGIBILITY.—To be eligible for a grant under this section, an entity shall be—

''(1) a State, local, or tribal department of health;

''(2) a public or private nonprofit entity; or

''(3) a consortium of 2 or more entities described in paragraphs (1) and (2).

''(c) REPORT.—The Secretary shall submit to the Congress an annual report on the program of research under this section.

''Subtitle E—Delivery of Community Prevention and Wellness Services

''SEC. 3151. COMMUNITY PREVENTION AND WELLNESS SERVICES GRANTS.

''(a) IN GENERAL.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall establish a program for the delivery of community preventive and wellness services consisting of awarding grants to eligible entities—

''(1) to provide evidence-based, community preventive and wellness services in priority areas identi-

fied by the Secretary in the national strategy under section 3121; or

''(2) to plan such services.

''(b) ELIGIBILITY.—

''(1) DEFINITION.—To be eligible for a grant under this section, an entity shall be—

''(A) a State, local, or tribal department of health;

''(B) a public or private entity; or

''(C) a consortium of—

''(i) 2 or more entities described in subparagraph (A) or (B); and

''(ii) a community partnership representing a Health Empowerment Zone.

''(2) HEALTH EMPOWERMENT ZONE.—In this subsection, the term 'Health Empowerment Zone' means an area—

''(A) in which multiple community preventive and wellness services are implemented in order to address one or more health disparities, including those identified by the Secretary in the national strategy under section 3121; and

''(B) which is represented by a community partnership that demonstrates community sup-

port and coordination with State, local, or tribal health departments and includes—

''(i) a broad cross section of stakeholders;

''(ii) residents of the community; and

''(iii) representatives of entities that have a history of working within and serving the community.

''(c) PREFERENCES.—In awarding grants under this section, the Secretary shall give preference to entities that—

''(1) will address one or more goals or objectives identified by the Secretary in the national strategy under section 3121;

''(2) will address significant health disparities, including those identified by the Secretary in the national strategy under section 3121;

''(3) will address unmet community prevention needs and avoids duplication of effort;

''(4) have been demonstrated to be effective in communities comparable to the proposed target community;

''(5) will contribute to the evidence base for community preventive and wellness services;

''(6) demonstrate that the community preventive services to be funded will be sustainable; and

''(7) demonstrate coordination or collaboration across governmental and nongovernmental partners.

''(d) HEALTH DISPARITIES.—Of the funds awarded under this section for a fiscal year, the Secretary shall award not less than 50 percent for planning or implementing community preventive and wellness services whose primary purpose is to achieve a measurable reduction in one or more health disparities, including those identified by the Secretary in the national strategy under section 3121.

''(e) EMPHASIS ON RECOMMENDED SERVICES.—For fiscal year 2013 and subsequent fiscal years, the Secretary shall award grants under this section only for planning or implementing services recommended by the Task Force on Community Preventive Services under section 3122 or deemed effective based on a review of comparable rigor (as determined by the Director of the Centers for Disease Control and Prevention).

''(f) PROHIBITED USES OF FUNDS.—An entity that receives a grant under this section may not use funds provided through the grant—

''(1) to build or acquire real property or for construction; or

''(2) for services or planning to the extent that payment has been made, or can reasonably be expected to be made—

''(A) under any insurance policy;

''(B) under any Federal or State health benefits program (including titles XIX and XXI of the Social Security Act); or

''(C) by an entity which provides health services on a prepaid basis.

''(g) REPORT.—The Secretary shall submit to the Congress an annual report on the program of grants awarded under this section.

''(h) DEFINITIONS.—In this section, the term 'evidence-based' means that methodologically sound research has demonstrated a beneficial health effect, in the judgment of the Director of the Centers for Disease Control and Prevention.

''Subtitle F—Core Public Health Infrastructure

''SEC. 3161. CORE PUBLIC HEALTH INFRASTRUCTURE FOR STATE, LOCAL, AND TRIBAL HEALTH DEPARTMENTS.

''(a) PROGRAM.—The Secretary, acting through the Director of the Centers for Disease Control and Preven-

tion shall establish a core public health infrastructure program consisting of awarding grants under subsection (b).

''(b) GRANTS.—

''(1) AWARD.—For the purpose of addressing core public health infrastructure needs, the Secretary—

''(A) shall award a grant to each State health department; and

''(B) may award grants on a competitive basis to State, local, or tribal health departments.

''(2) ALLOCATION.—Of the total amount of funds awarded as grants under this subsection for a fiscal year—

''(A) not less than 50 percent shall be for grants to State health departments under paragraph (1)(A); and

''(B) not less than 30 percent shall be for grants to State, local, or tribal health departments under paragraph (1)(B).

''(c) USE OF FUNDS.—The Secretary may award a grant to an entity under subsection (b)(1) only if the entity agrees to use the grant to address core public health infrastructure needs, including those identified in the accreditation process under subsection (g).

''(d) FORMULA GRANTS TO STATE HEALTH DEPARTMENTS.—In making grants under subsection (b)(1)(A), the Secretary shall award funds to each State health department in accordance with—

''(1) a formula based on population size; burden of preventable disease and disability; and core public health infrastructure gaps, including those identified in the accreditation process under subsection (g); and

''(2) application requirements established by the Secretary, including a requirement that the State submit a plan that demonstrates to the satisfaction of the Secretary that the State's health department will—

''(A) address its highest priority core public health infrastructure needs; and

''(B) as appropriate, allocate funds to local health departments within the State.

''(e) COMPETITIVE GRANTS TO STATE, LOCAL, AND TRIBAL HEALTH DEPARTMENTS.—In making grants under subsection (b)(1)(B), the Secretary shall give priority to applicants demonstrating core public health infrastructure needs identified in the accreditation process under subsection (g).

''(f) MAINTENANCE OF EFFORT.—The Secretary may award a grant to an entity under subsection (b) only if the entity demonstrates to the satisfaction of the Secretary that—

''(1) funds received through the grant will be expended only to supplement, and not supplant, non-Federal and Federal funds otherwise available to the entity for the purpose of addressing core public health infrastructure needs; and

''(2) with respect to activities for which the grant is awarded, the entity will maintain expenditures of non-Federal amounts for such activities at a level not less than the level of such expenditures maintained by the entity for the fiscal year preceding the fiscal year for which the entity receives the grant.

''(g) ESTABLISHMENT OF A PUBLIC HEALTH ACCREDITATION PROGRAM.—

''(1) IN GENERAL.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall—

''(A) develop, and periodically review and update, standards for voluntary accreditation of State, local, or tribal health departments and public health laboratories for the purpose of ad-

vancing the quality and performance of such departments and laboratories; and

''(B) implement a program to accredit such health departments and laboratories in accordance with such standards.

''(2) COOPERATIVE AGREEMENT.—The Secretary may enter into a cooperative agreement with a private nonprofit entity to carry out paragraph (1).

''(h) REPORT.—The Secretary shall submit to the Congress an annual report on progress being made to accredit entities under subsection (g), including—

''(1) a strategy, including goals and objectives, for accrediting entities under subsection (g) and achieving the purpose described in subsection (g)(1); and

''(2) identification of gaps in research related to core public health infrastructure and recommendations of priority areas for such research.

''SEC. 3162. CORE PUBLIC HEALTH INFRASTRUCTURE AND ACTIVITIES FOR CDC.

''(a) IN GENERAL.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall expand and improve the core public health infrastructure and activities of the Centers for Disease

Control and Prevention to address unmet and emerging public health needs.

''(b) REPORT.—The Secretary shall submit to the Congress an annual report on the activities funded through this section.

''Subtitle G—General Provisions

''**SEC. 3171. DEFINITIONS.**

''In this title:

''(1) The term 'core public health infrastructure' includes workforce capacity and competency; laboratory systems; health information, health information systems, and health information analysis; communications; financing; other relevant components of organizational capacity; and other related activities.

''(2) The terms 'Department' and 'departmental' refer to the Department of Health and Human Services.

''(3) The term 'health disparities' includes health and health care disparities and means population-specific differences in the presence of disease, health outcomes, or access to health care. For purposes of the preceding sentence, a population may be delineated by race, ethnicity, geographic setting, or

other population or subpopulation determined appropriate by the Secretary.

''(4) The term 'tribal' refers to an Indian tribe, a Tribal organization, or an Urban Indian organization, as such terms are defined in section 4 of the Indian Health Care Improvement Act.''.

(b) TRANSITION PROVISIONS APPLICABLE TO TASK FORCES.—

(1) FUNCTIONS, PERSONNEL, ASSETS, LIABILITIES, AND ADMINISTRATIVE ACTIONS.—All functions, personnel, assets, and liabilities of, and administrative actions applicable to, the Preventive Services Task Force convened under section 915(a) of the Public Health Service Act and the Task Force on Community Preventive Services (as such section and Task Forces were in existence on the day before the date of the enactment of this Act) shall be transferred to the Task Force on Clinical Preventive Services and the Task Force on Community Preventive Services, respectively, established under sections 3121 and 3122 of the Public Health Service Act, as added by subsection (a).

(2) RECOMMENDATIONS.—All recommendations of the Preventive Services Task Force and the Task Force on Community Preventive Services, as in ex-

istence on the day before the date of the enactment of this Act, shall be considered to be recommendations of the Task Force on Clinical Preventive Services and the Task Force on Community Preventive Services, respectively, established under sections 3121 and 3122 of the Public Health Service Act, as added by subsection (a).

(3) MEMBERS ALREADY SERVING.—

(A) INITIAL MEMBERS.—The Secretary of Health and Human Services may select those individuals already serving on the Preventive Services Task Force and the Task Force on Community Preventive Services, as in existence on the day before the date of the enactment of this Act, to be among the first members appointed to the Task Force on Clinical Preventive Services and the Task Force on Community Preventive Services, respectively, under sections 3121 and 3122 of the Public Health Service Act, as added by subsection (a).

(B) CALCULATION OF TOTAL SERVICE.—In calculating the total years of service of a member of a task force for purposes of section 3131(d)(2)(A) or 3132(d)(2)(A) of the Public Health Service Act, as added by subsection (a),

the Secretary of Health and Human Services shall not include any period of service by the member on the Preventive Services Task Force or the Task Force on Community Preventive Services, respectively, as in existence on the day before the date of the enactment of this Act.

(c) PERIOD BEFORE COMPLETION OF NATIONAL STRATEGY.—Pending completion of the national strategy under section 3121 of the Public Health Service Act, as added by subsection (a), the Secretary of Health and Human Services, acting through the relevant agency head, may make a judgment about how the strategy will address an issue and rely on such judgment in carrying out any provision of subtitle C, D, E, or F of title XXXI of such Act, as added by subsection (a), that requires the Secretary—

(1) to take into consideration such strategy;

(2) to conduct or support research or provide services in priority areas identified in such strategy; or

(3) to take any other action in reliance on such strategy.

(d) CONFORMING AMENDMENTS.—

(1) Paragraph (61) of section 3(b) of the Indian Health Care Improvement Act (25 U.S.C.

1602) is amended by striking ''United States Preventive Services Task Force'' and inserting ''Task Force on Clinical Preventive Services''.

(2) Section 126 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (Appendix F of Public Law 106–554) is amended by striking ''United States Preventive Services Task Force'' each place it appears and inserting ''Task Force on Clinical Preventive Services''.

(3) Paragraph (7) of section 317D of the Public Health Service Act (42 U.S.C. 247b–5) is amended by striking ''United States Preventive Services Task Force'' each place it appears and inserting ''Task Force on Clinical Preventive Services''.

(4) Section 915 of the Public Health Service Act (42 U.S.C. 299b-4) is amended by striking subsection (a).

(5) Subsections (s)(2)(AA)(iii)(II), (xx)(1), and (ddd)(1)(B) of section 1861 of the Social Security Act (42 U.S.C. 1395x) are amended by striking ''United States Preventive Services Task Force'' each place it appears and inserting ''Task Force on Clinical Preventive Services''.

TITLE IV—QUALITY AND SURVEILLANCE

SEC. 2401. IMPLEMENTATION OF BEST PRACTICES IN THE DELIVERY OF HEALTH CARE.

(a) IN GENERAL.—Title IX of the Public Health Service Act (42 U.S.C. 299 et seq.) is amended—

(1) by redesignating part D as part E;

(2) by redesignating sections 931 through 938 as sections 941 through 948, respectively;

(3) in section 938(1), by striking ''931'' and inserting ''941''; and

(4) by inserting after part C the following:

''PART D—IMPLEMENTATION OF BEST PRACTICES IN THE DELIVERY OF HEALTH CARE

''SEC. 931. CENTER FOR QUALITY IMPROVEMENT.

''(a) IN GENERAL.—There is established the Center for Quality Improvement (referred to in this part as the 'Center'), to be headed by the Director.

''(b) PRIORITIZATION.—

''(1) IN GENERAL.—The Director shall prioritize areas for the identification, development, evaluation, and implementation of best practices (including innovative methodologies and strategies) for quality improvement activities in the delivery of

health care services (in this section referred to as 'best practices').

''(2) CONSIDERATIONS.—In prioritizing areas under paragraph (1), the Director shall consider—

''(A) the priorities established under section 1191 of the Social Security Act; and

''(B) the key health indicators identified by the Assistant Secretary for Health Information under section 1709.

''(c) OTHER RESPONSIBILITIES.—The Director, acting directly or by awarding a grant or contract to an eligible entity, shall—

''(1) identify existing best practices under subsection (e);

''(2) develop new best practices under subsection (f);

''(3) evaluate best practices under subsection (g);

''(4) implement best practices under subsection (h);

''(5) ensure that best practices are identified, developed, evaluated, and implemented under this section consistent with standards adopted by the Secretary under section 3004 for health information technology used in the collection and reporting of

quality information (including for purposes of the demonstration of meaningful use of certified electronic health record (EHR) technology by physicians and hospitals under the Medicare program (under sections 1848(o)(2) and 1886(n)(3), respectively, of the Social Security Act)); and

''(6) provide for dissemination of information and reporting under subsections (i) and (j).

''(d) ELIGIBILITY.—To be eligible for a grant or contract under subsection (c), an entity shall—

''(1) be a nonprofit entity;

''(2) agree to work with a variety of institutional health care providers, physicians, nurses, and other health care practitioners; and

''(3) if the entity is not the organization holding a contract under section 1153 of the Social Security Act for the area to be served, agree to cooperate with and avoid duplication of the activities of such organization.

''(e) IDENTIFYING EXISTING BEST PRACTICES.—The Secretary shall identify best practices that are—

''(1) currently utilized by health care providers (including hospitals, physician and other clinician practices, community cooperatives, and other health

care entities) that deliver consistently high-quality, efficient health care services; and

''(2) easily adapted for use by other health care providers and for use across a variety of health care settings.

''(f) DEVELOPING NEW BEST PRACTICES.—The Secretary shall develop best practices that are—

''(1) based on a review of existing scientific evidence;

''(2) sufficiently detailed for implementation and incorporation into the workflow of health care providers; and

''(3) designed to be easily adapted for use by health care providers across a variety of health care settings.

''(g) EVALUATION OF BEST PRACTICES.—The Director shall evaluate best practices identified or developed under this section. Such evaluation—

''(1) shall include determinations of which best practices—

''(A) most reliably and effectively achieve significant progress in improving the quality of patient care; and

''(B) are easily adapted for use by health care providers across a variety of health care settings;

''(2) shall include regular review, updating, and improvement of such best practices; and

''(3) may include in-depth case studies or empirical assessments of health care providers (including hospitals, physician and other clinician practices, community cooperatives, and other health care entities) and simulations of such best practices for determinations under paragraph (1).

''(h) IMPLEMENTATION OF BEST PRACTICES.—

''(1) IN GENERAL.—The Director shall enter into voluntary arrangements with health care providers (including hospitals and other health facilities and health practitioners) in a State or region to implement best practices identified or developed under this section. Such implementation—

''(A) may include forming collaborative multi-institutional teams; and

''(B) shall include an evaluation of the best practices being implemented, including the measurement of patient outcomes before, during, and after implementation of such best practices.

''(2) PREFERENCES.—In carrying out this subsection, the Director shall give priority to health care providers implementing best practices that—

''(A) have the greatest impact on patient outcomes and satisfaction;

''(B) are the most easily adapted for use by health care providers across a variety of health care settings;

''(C) promote coordination of health care practitioners across the continuum of care; and

''(D) engage patients and their families in improving patient care and outcomes.

''(i) PUBLIC DISSEMINATION OF INFORMATION.—The Director shall provide for the public dissemination of information with respect to best practices and activities under this section. Such information shall be made available in appropriate formats and languages to reflect the varying needs of consumers and diverse levels of health literacy.

''(j) REPORT.—

''(1) IN GENERAL.—The Director shall submit an annual report to the Congress and the Secretary on activities under this section.

''(2) CONTENT.—Each report under paragraph (1) shall include—

''(A) information on activities conducted pursuant to grants and contracts awarded;

''(B) summary data on patient outcomes before, during, and after implementation of best practices; and

''(C) recommendations on the adaptability of best practices for use by health providers.''.

(b) INITIAL QUALITY IMPROVEMENT ACTIVITIES AND INITIATIVES TO BE IMPLEMENTED.—Until the Director of the Agency for Healthcare Research and Quality has established initial priorities under section 931(b) of the Public Health Service Act, as added by subsection (a), the Director shall, for purposes of such section, prioritize the following:

(1) HEALTH CARE-ASSOCIATED INFECTIONS.—Reducing health care-associated infections, including infections in nursing homes and outpatient settings.

(2) SURGERY.—Increasing hospital and outpatient perioperative patient safety, including reducing surgical-site infections and surgical errors (such as wrong-site surgery and retained foreign bodies).

(3) EMERGENCY ROOM.—Improving care in hospital emergency rooms, including through the use of principles of efficiency of design and delivery to improve patient flow.

(4) OBSTETRICS.—Improving the provision of obstetrical and neonatal care, including the identification of interventions that are effective in reducing the risk of preterm and premature labor and the implementation of best practices for labor and delivery care.

SEC. 2402. ASSISTANT SECRETARY FOR HEALTH INFORMATION.

(a) ESTABLISHMENT.— Title XVII (42 U.S.C. 300u et seq.) is amended—

(1) by redesignating sections 1709 and 1710 as sections 1710 and 1711, respectively; and

(2) by inserting after section 1708 the following:

"**SEC. 1709. ASSISTANT SECRETARY FOR HEALTH INFORMATION.**

''(a) IN GENERAL.—There is established within the Department an Assistant Secretary for Health Information (in this section referred to as the 'Assistant Secretary'), to be appointed by the Secretary.

''(b) RESPONSIBILITIES.—The Assistant Secretary shall—

''(1) ensure the collection, collation, reporting, and publishing of information (including full and complete statistics) on key health indicators regard-

ing the Nation's health and the performance of the Nation's health care;

''(2) facilitate and coordinate the collection, collation, reporting, and publishing of information regarding the Nation's health and the performance of the Nation's health care (other than information described in paragraph (1));

''(3)(A) develop standards for the collection of data regarding the Nation's health and the performance of the Nation's health care; and

''(B) in carrying out subparagraph (A)—

''(i) ensure appropriate specificity and standardization for data collection at the national, regional, State, and local levels;

''(ii) include standards, as appropriate, for the collection of accurate data on health and health care by race, ethnicity, primary language, sex, sexual orientation, gender identity, disability, socioeconomic status, rural, urban, or other geographic setting, and any other population or subpopulation determined appropriate by the Secretary;

''(iii) ensure, with respect to data on race and ethnicity, consistency with the 1997 Office of Management and Budget Standards for

Maintaining, Collecting and Presenting Federal Data on Race and Ethnicity (or any successor standards); and

''(iv) in consultation with the Director of the Office of Minority Health, and the Director of the Office of Civil Rights, of the Department, develop standards for the collection of data on health and health care with respect to data on primary language;

''(4) provide support to Federal departments and agencies whose programs have a significant impact upon health (as determined by the Secretary) for the collection and collation of information described in paragraphs (1) and (2);

''(5) ensure the sharing of information described in paragraphs (1) and (2) among the agencies of the Department;

''(6) facilitate the sharing of information described in paragraphs (1) and (2) by Federal departments and agencies whose programs have a significant impact upon health (as determined by the Secretary);

''(7) identify gaps in information described in paragraphs (1) and (2) and the appropriate agency or entity to address such gaps;

''(8) facilitate and coordinate identification and monitoring by the agencies of the Department of health disparities to inform program and policy efforts to reduce such disparities, including facilitating and funding analyses conducted in cooperation with the Social Security Administration, the Bureau of the Census, and other appropriate agencies and entities;

''(9) consistent with privacy, proprietary, and other appropriate safeguards, facilitate public accessibility of datasets (such as de-identified Medicare datasets or publicly available data on key health indicators) by means of the Internet; and

''(10) award grants or contracts for the collection and collation of information described in paragraphs (1) and (2) (including through statewide surveys that provide standardized information).

''(c) KEY HEALTH INDICATORS.—

''(1) IN GENERAL.—In carrying out subsection (b)(1), the Assistant Secretary shall—

''(A) identify, and reassess at least once every 3 years, key health indicators described in such subsection;

''(B) publish statistics on such key health indicators for the public—

''(i) not less than annually; and

''(ii) on a supplemental basis whenever warranted by—

''(I) the rate of change for a key health indicator; or

''(II) the need to inform policy regarding the Nation's health and the performance of the Nation's health care; and

''(C) ensure consistency with the national strategy developed by the Secretary under section 3121 and consideration of the indicators specified in the reports under sections 308, 903(a)(6), and 913(b)(2).

''(2) RELEASE OF KEY HEALTH INDICATORS.—The regulations, rules, processes, and procedures of the Office of Management and Budget governing the review, release, and dissemination of key health indicators shall be the same as the regulations, rules, processes, and procedures of the Office of Management and Budget governing the review, release, and dissemination of Principal Federal Economic Indicators (or equivalent statistical data) by the Bureau of Labor Statistics.

''(d) COORDINATION.—In carrying out this section, the Assistant Secretary shall coordinate with—

''(1) public and private entities that collect and disseminate information on health and health care, including foundations; and

''(2) the head of the Office of the National Coordinator for Health Information Technology to ensure optimal use of health information technology.

''(e) REQUEST FOR INFORMATION FROM OTHER DEPARTMENTS AND AGENCIES.—Consistent with applicable law, the Assistant Secretary may secure directly from any Federal department or agency information necessary to enable the Assistant Secretary to carry out this section.

''(f) REPORT.—

''(1) SUBMISSION.—The Assistant Secretary shall submit to the Secretary and the Congress an annual report containing—

''(A) a description of national, regional, or State changes in health or health care, as reflected by the key health indicators identified under subsection (c)(1);

''(B) a description of gaps in the collection, collation, reporting, and publishing of information regarding the Nation's health and the performance of the Nation's health care;

''(C) recommendations for addressing such gaps and identification of the appropriate agency within the Department or other entity to address such gaps;

''(D) a description of analyses of health disparities, including the results of completed analyses, the status of ongoing longitudinal studies, and proposed or planned research; and

''(E) a plan for actions to be taken by the Assistant Secretary to address gaps described in subparagraph (B).

''(2) CONSIDERATION.—In preparing a report under paragraph (1), the Assistant Secretary shall take into consideration the findings and conclusions in the reports under sections 308, 903(a)(6), and 913(b)(2).

''(g) PROPRIETARY AND PRIVACY PROTECTIONS.—Nothing in this section shall be construed to affect applicable proprietary or privacy protections.

''(h) CONSULTATION.—In carrying out this section, the Assistant Secretary shall consult with—

''(1) the heads of appropriate health agencies and offices in the Department, including the Office of the Surgeon General of the Public Health Service,

the Office of Minority Health, and the Office on Women's Health; and

''(2) as appropriate, the heads of other Federal departments and agencies whose programs have a significant impact upon health (as determined by the Secretary).

''(i) DEFINITION.—In this section:

''(1) The terms 'agency' and 'agencies' include an epidemiology center established under section 214 of the Indian Health Care Improvement Act.

''(2) The term 'Department' means the Department of Health and Human Services.

''(3) The term 'health disparities' has the meaning given to such term in section 3171.''.

(b) OTHER COORDINATION RESPONSIBILITIES.—Title III (42 U.S.C. 241 et seq.) is amended—

(1) in paragraphs (1) and (2) of section 304(c) (42 U.S.C. 242b(c)), by inserting '', acting through the Assistant Secretary for Health Information,'' after ''The Secretary'' each place it appears; and

(2) in section 306(j) (42 U.S.C. 242k(j)), by inserting '', acting through the Assistant Secretary for Health Information,'' after ''of this section, the Secretary''.

SEC. 2403. AUTHORIZATION OF APPROPRIATIONS.

Section 799C, as added and amended, is further amended by adding at the end the following:

''(e) QUALITY AND SURVEILLANCE.—For the purpose of carrying out part D of title IX and section 1709, in addition to any other amounts authorized to be appropriated for such purpose, there is authorized to be appropriated, out of any monies in the Public Health Investment Fund, $300,000,000 for each of fiscal years 2010 through 2014 and $330,000,000 for each of fiscal years 2015 through 2019.''.

TITLE V—OTHER PROVISIONS

Subtitle A—Drug Discount for Rural and Other Hospitals

SEC. 2501. EXPANDED PARTICIPATION IN 340B PROGRAM.

(a) EXPANSION OF COVERED ENTITIES RECEIVING DISCOUNTED PRICES.—Section 340B(a)(4) (42 U.S.C. 256b(a)(4)) is amended by adding at the end the following:

''(M) A children's hospital excluded from the Medicare prospective payment system pursuant to section 1886(d)(1)(B)(iii) of the Social Security Act which would meet the requirements of subparagraph (L), including the disproportionate share adjustment percentage requirement under subparagraph (L)(ii), if the

hospital were a subsection (d) hospital as defined in section 1886(d)(1)(B) of the Social Security Act.

''(N) An entity that is a critical access hospital (as determined under section 1820(c)(2) of the Social Security Act).

''(O) An entity receiving funds under title V of the Social Security Act (relating to maternal and child health) for the provision of health services.

''(P) An entity receiving funds under subpart I of part B of title XIX of the Public Health Service Act (relating to comprehensive mental health services) for the provision of community mental health services.

''(Q) An entity receiving funds under subpart II of such part B (relating to the prevention and treatment of substance abuse) for the provision of treatment services for substance abuse.

''(R) An entity that is a Medicare-dependent, small rural hospital (as defined in section 1886(d)(5)(G)(iv) of the Social Security Act).

''(S) An entity that is a sole community hospital (as defined in section 1886(d)(5)(D)(iii) of the Social Security Act).

''(T) An entity that is classified as a rural referral center under section 1886(d)(5)(C) of the Social Security Act.''.

(b) PROHIBITION ON GROUP PURCHASING ARRANGEMENTS.—Section 340B(a) (42 U.S.C. 256b(a)) is amended—

(1) in paragraph (4)(L)—

(A) by adding ''and'' at the end of clause (i);

(B) by striking ''; and'' at the end of clause (ii) and inserting a period; and

(C) by striking clause (iii);

(2) in paragraph (5), by redesignating subparagraphs (C) and (D) as subparagraphs (D) and (E), respectively, and by inserting after subparagraph (B) the following:

''(C) PROHIBITING USE OF GROUP PURCHASING ARRANGEMENTS.—

''(i) A hospital described in subparagraph (L), (M), (N), (R), (S), or (T) of paragraph (4) shall not obtain covered outpatient drugs through a group purchasing

organization or other group purchasing arrangement, except as permitted or provided pursuant to clause (ii).

''(ii) The Secretary shall establish reasonable exceptions to the requirement of clause (i)—

''(I) with respect to a covered outpatient drug that is unavailable to be purchased through the program under this section due to a drug shortage problem, manufacturer noncompliance, or any other reason beyond the hospital's control;

''(II) to facilitate generic substitution when a generic covered outpatient drug is available at a lower price; and

''(III) to reduce in other ways the administrative burdens of managing both inventories of drugs obtained under this section and not under this section, if such exception does not create a duplicate discount problem in violation of subparagraph

(A) or a diversion problem in violation of subparagraph (B).''.

SEC. 2502. EXTENSION OF DISCOUNTS TO INPATIENT DRUGS.

(a) IN GENERAL.—Section 340B (42 U.S.C. 256b) is amended—

(1) in subsection (b)—

(A) by striking ''In this section, the terms'' and inserting the following: ''In this section:

''(1) IN GENERAL.—The terms''; and

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

''(2) COVERED DRUG.—The term 'covered drug'—

''(A) means a covered outpatient drug (as defined in section 1927(k)(2) of the Social Security Act); and

''(B) includes, notwithstanding the section 1927(k)(3)(A) of such Act, a drug used in connection with an inpatient or outpatient service provided by a hospital described in subparagraph (L), (M), (N), (R), (S), or (T) of subsection (a)(4) that is enrolled to participate in the drug discount program under this section.''; and

(2) in paragraphs (5), (7), and (9) of subsection (a), by striking ''outpatient'' each place it appears.

(b) MEDICAID CREDITS ON INPATIENT DRUGS.—Subsection (c) of section 340B (42 U.S.C. 256b(c)) is amended to read as follows:

''(c) MEDICAID CREDITS ON INPATIENT DRUGS.—

''(1) IN GENERAL.—For the cost reporting period covered by the most recently filed Medicare cost report under title XVIII of the Social Security Act, a hospital described in subparagraph (L), (M), (N), (R), (S), or (T) of subsection (a)(4) and enrolled to participate in the drug discount program under this section shall provide to each State under its plan under title XIX of such Act—

''(A) a credit on the estimated annual costs to such hospital of single source and innovator multiple source drugs provided to Medicaid beneficiaries for inpatient use; and

''(B) a credit on the estimated annual costs to such hospital of noninnovator multiple source drugs provided to Medicaid beneficiaries for inpatient use.

''(2) AMOUNT OF CREDITS.—

''(A) SINGLE SOURCE AND INNOVATOR MULTIPLE SOURCE DRUGS.—For purposes of paragraph (1)(A)—

''(i) the credit under such paragraph shall be equal to the product of—

''(I) the annual value of single source and innovator multiple source drugs purchased under this section by the hospital based on the drugs' average manufacturer price;

''(II) the estimated percentage of the hospital's drug purchases attributable to Medicaid beneficiaries for inpatient use; and

''(III) the minimum rebate percentage described in section 1927(c)(1)(B) of the Social Security Act;

''(ii) the reference in clause (i)(I) to the annual value of single source and innovator multiple source drugs purchased under this section by the hospital based on the drugs' average manufacturer price shall be equal to the sum of—

''(I) the annual quantity of each single source and innovator multiple source drug purchased during the cost reporting period, multiplied by

''(II) the average manufacturer price for that drug;

''(iii) the reference in clause (i)(II) to the estimated percentage of the hospital's drug purchases attributable to Medicaid beneficiaries for inpatient use; shall be equal to—

''(I) the Medicaid inpatient drug charges as reported on the hospital's most recently filed Medicare cost report, divided by

''(II) total drug charges reported on the cost report; and

''(iv) the terms 'single source drug' and 'innovator multiple source drug' have the meanings given such terms in section 1927(k)(7) of the Social Security Act.

''(B) NONINNOVATOR MULTIPLE SOURCE DRUGS.—For purposes of paragraph (1)(B)—

''(i) the credit under such paragraph shall be equal to the product of—

''(I) the annual value of noninnovator multiple source drugs purchased under this section by the hospital based on the drugs' average manufacturer price;

''(II) the estimated percentage of the hospital's drug purchases attributable to Medicaid beneficiaries for inpatient use; and

''(III) the applicable percentage as defined in section 1927(c)(3)(B) of the Social Security Act;

''(ii) the reference in clause (i)(I) to the annual value of noninnovator multiple source drugs purchased under this section by the hospital based on the drugs' average manufacturer price shall be equal to the sum of—

''(I) the annual quantity of each noninnovator multiple source drug purchased during the cost reporting period, multiplied by

''(II) the average manufacturer price for that drug;

''(iii) the reference in clause (i)(II) to the estimated percentage of the hospital's drug purchases attributable to Medicaid beneficiaries for inpatient use shall be equal to—

''(I) the Medicaid inpatient drug charges as reported on the hospital's most recently filed Medicare cost report, divided by

''(II) total drug charges reported on the cost report; and

''(iv) the term 'noninnovator multiple source drug' has the meaning given such term in section 1927(k)(7) of the Social Security Act.

''(3) CALCULATION OF CREDITS.—

''(A) IN GENERAL.—Each State calculates credits under paragraph (1) and informs hospitals of amount under section 1927(a)(5)(D) of the Social Security Act.

''(B) HOSPITAL PROVISION OF INFORMATION.—Not later than 30 days after the date of the filing of the hospital's most recently filed Medicare cost report, the hospital shall provide the State with the information described in

paragraphs (2)(A)(ii) and (2)(B)(ii). With respect to each drug purchased during the cost reporting period, the hospital shall provide the dosage form, strength, package size, date of purchase and the number of units purchased.

''(4) PAYMENT DEADLINE.—The credits provided by a hospital under paragraph (1) shall be paid within 60 days after receiving the information specified in paragraph (3)(A).

''(5) OPT OUT.—A hospital shall not be required to provide the Medicaid credit required under paragraph (1) if it can demonstrate to the State that it will lose reimbursement under the State plan resulting from the extension of discounts to inpatient drugs under subsection (b)(2) and that the loss of reimbursement will exceed the amount of the credit otherwise owed by the hospital.

''(6) OFFSET AGAINST MEDICAL ASSISTANCE.—Amounts received by a State under this subsection in any quarter shall be considered to be a reduction in the amount expended under the State plan in the quarter for medical assistance for purposes of section 1903(a)(1) of the Social Security Act.''.

(c) CONFORMING AMENDMENTS.—Section 1927 of the Social Security Act (42 U.S.C. 1396r–8) is amended—

(1) in subsection (a)(5)(A), by striking ''covered outpatient drugs'' and inserting ''covered drugs (as defined in section 340B(b)(2) of the Public Health Service Act)'';

(2) in subsection (a)(5), by striking subparagraph (D) and inserting the following:

''(D) STATE RESPONSIBILITY FOR CALCULATING HOSPITAL CREDITS.—The State shall calculate the credits owed by the hospital under paragraph (1) of section 340B(c) of the Public Health Service Act and provide the hospital with both the amounts and an explanation of how it calculated the credits. In performing the calculations specified in paragraphs (2)(A)(ii) and (2)(B)(ii) of such section, the State shall use the average manufacturer price applicable to the calendar quarter in which the drug was purchased by the hospital.''; and

(3) in subsection (k)(1)—

(A) in subparagraph (A), by striking ''subparagraph (B)'' and inserting ''subparagraphs (B) and (D)''; and

(B) by adding at the end the following:

''(D) CALCULATION FOR COVERED DRUGS.—With respect to a covered drug (as de-

fined in section 340B(b)(2) of the Public Health Service Act), the average manufacturer price shall be determined in accordance with subparagraph (A) except that, in the event a covered drug is not distributed to the retail pharmacy class of trade, it shall mean the average price paid to the manufacturer for the drug in the United States by wholesalers for drugs distributed to the acute care class of trade, after deducting customary prompt pay discounts.''.

SEC. 2503. EFFECTIVE DATE.

(a) IN GENERAL.—The amendments made by this subtitle shall take effect on July 1, 2010, and shall apply to drugs dispensed on or after such date.

(b) EFFECTIVENESS.—The amendments made by this subtitle shall be effective, and shall be taken into account in determining whether a manufacturer is deemed to meet the requirements of section 340B(a) of the Public Health Service Act (42 U.S.C. 256b(a)) and of section 1927(a)(5) of the Social Security Act (42 U.S.C. 1396r–8(a)(5)), notwithstanding any other provision of law.

Subtitle B—School-Based Health Clinics

SEC. 2511. SCHOOL-BASED HEALTH CLINICS.

(a) IN GENERAL.—Part Q of title III (42 U.S.C. 280h et seq.) is amended by adding at the end the following:

"**SEC. 399Z–1. SCHOOL-BASED HEALTH CLINICS.**

''(a) PROGRAM.—The Secretary shall establish a school-based health clinic program consisting of awarding grants to eligible entities to support the operation of school-based health clinics (referred to in this section as 'SBHCs').

''(b) ELIGIBILITY.—To be eligible for a grant under this section, an entity shall—

''(1) be an SBHC (as defined in subsection (l)(4)); and

''(2) submit an application at such time, in such manner, and containing such information as the Secretary may require, including at a minimum—

''(A) evidence that the applicant meets all criteria necessary to be designated as an SBHC;

''(B) evidence of local need for the services to be provided by the SBHC;

''(C) an assurance that—

''(i) SBHC services will be provided in accordance with Federal, State, and local laws governing—

''(I) obtaining parental or guardian consent; and

''(II) patient privacy and student records, including section 264 of the Health Insurance Portability and Accountability Act of 1996 and section 444 of the General Education Provisions Act;

''(ii) the SBHC has established and maintains collaborative relationships with other health care providers in the catchment area of the SBHC;

''(iii) the SBHC will provide on-site access during the academic day when school is in session and has an established network of support and access to services with backup health providers when the school or SBHC is closed;

''(iv) the SBHC will be integrated into the school environment and will coordinate health services with appropriate school per-

sonnel and other community providers co-located at the school; and

''(v) the SBHC sponsoring facility assumes all responsibility for the SBHC administration, operations, and oversight; and

''(D) such other information as the Secretary may require.

''(c) USE OF FUNDS.—Funds awarded under a grant under this section may be used for—

''(1) providing training related to the provision of comprehensive primary health services and additional health services;

''(2) the management and operation of SBHC programs; and

''(3) the payment of salaries for health professionals and other appropriate SBHC personnel.

''(d) CONSIDERATION OF NEED.—In determining the amount of a grant under this section, the Secretary shall take into consideration—

''(1) the financial need of the SBHC;

''(2) State, local, or other sources of funding provided to the SBHC; and

''(3) other factors as determined appropriate by the Secretary.

''(e) PREFERENCES.—In awarding grants under this section, the Secretary shall give preference to SBHCs that have a demonstrated record of service to the following:

''(1) A high percentage of medically underserved children and adolescents.

''(2) Communities or populations in which children and adolescents have difficulty accessing health and mental health services.

''(3) Communities with high percentages of children and adolescents who are uninsured, underinsured, or eligible for medical assistance under Federal or State health benefits programs (including titles XIX and XXI of the Social Security Act).

''(f) MATCHING REQUIREMENT.—The Secretary may award a grant to an SBHC only if the SBHC agrees to provide, from non-Federal sources, an amount equal to 20 percent of the amount of the grant (which may be provided in cash or in kind) to carry out the activities supported by the grant.

''(g) SUPPLEMENT, NOT SUPPLANT.—The Secretary may award a grant to an SBHC under this section only if the SBHC demonstrates to the satisfaction of the Secretary that funds received through the grant will be expended only to supplement, and not supplant, non-Federal and Federal funds otherwise available to the SBHC for

operation of the SBHC (including each activity described in paragraph (1) or (2) of subsection (c)).

''(h) PAYOR OF LAST RESORT.—The Secretary may award a grant to an SBHC under this section only if the SBHC demonstrates to the satisfaction of the Secretary that funds received through the grant will not be expended for any activity to the extent that payment has been made, or can reasonably be expected to be made—

''(1) under any insurance policy;

''(2) under any Federal or State health benefits program (including titles XIX and XXI of the Social Security Act); or

''(3) by an entity which provides health services on a prepaid basis.

''(i) REGULATIONS REGARDING REIMBURSEMENT FOR HEALTH SERVICES.—The Secretary shall issue regulations regarding the reimbursement for health services provided by SBHCs to individuals eligible to receive such services through the program under this section, including reimbursement under any insurance policy or any Federal or State health benefits program (including titles XIX and XXI of the Social Security Act).

''(j) TECHNICAL ASSISTANCE.—The Secretary shall provide (either directly or by grant or contract) technical and other assistance to SBHCs to assist such SBHCs to

meet the requirements of this section. Such assistance may include fiscal and program management assistance, training in fiscal and program management, operational and administrative support, and the provision of information to the SBHCs of the variety of resources available under this title and how those resources can be best used to meet the health needs of the communities served by the SBHCs.

''(k) EVALUATION; REPORT.—The Secretary shall—

''(1) develop and implement a plan for evaluating SBHCs and monitoring quality performances under the awards made under this section; and

''(2) submit to the Congress on an annual basis a report on the program under this section.

''(l) DEFINITIONS.—In this section:

''(1) COMPREHENSIVE PRIMARY HEALTH SERVICES.—The term 'comprehensive primary health services' means the core services offered by SBHCs, which shall include the following:

''(A) PHYSICAL.—Comprehensive health assessments, diagnosis, and treatment of minor, acute, and chronic medical conditions and referrals to, and follow-up for, specialty care.

''(B) MENTAL HEALTH.—Mental health assessments, crisis intervention, counseling,

treatment, and referral to a continuum of services including emergency psychiatric care, community support programs, inpatient care, and outpatient programs.

''(C) OPTIONAL SERVICES.—Additional services, which may include oral health, social, and age-appropriate health education services, including nutritional counseling.

''(2) MEDICALLY UNDERSERVED CHILDREN AND ADOLESCENTS.—The term 'medically underserved children and adolescents' means a population of children and adolescents who are residents of an area designated by the Secretary as an area with a shortage of personal health services and health infrastructure for such children and adolescents.

''(3) SCHOOL-BASED HEALTH CLINIC.—The term 'school-based health clinic' means a health clinic that—

''(A) is located in, or is adjacent to, a school facility of a local educational agency;

''(B) is organized through school, community, and health provider relationships;

''(C) is administered by a sponsoring facility; and

''(D) provides, at a minimum, comprehensive primary health services during school hours to children and adolescents by health professionals in accordance with State and local laws and regulations, established standards, and community practice.

''(4) SPONSORING FACILITY.—The term 'sponsoring facility' is—

''(A) a hospital;

''(B) a public health department;

''(C) a community health center;

''(D) a nonprofit health care agency;

''(E) a local educational agency; or

''(F) a program administered by the Indian Health Service or the Bureau of Indian Affairs or operated by an Indian tribe or a tribal organization under the Indian Self-Determination and Education Assistance Act, a Native Hawaiian entity, or an urban Indian program under title V of the Indian Health Care Improvement Act.

''(m) AUTHORIZATION OF APPROPRIATIONS.—For purposes of carrying out this section, there are authorized to be appropriated $50,000,000 for fiscal year 2010 and

such sums as may be necessary for each of the fiscal years 2011 through 2014.''.

(b) EFFECTIVE DATE.—The Secretary of Health and Human Services shall begin awarding grants under section 399Z–1 of the Public Health Service Act, as added by subsection (b), not later than July 1, 2010, without regard to whether or not final regulations have been issued under section 399Z–1(h) of such Act

Subtitle C—National Medical Device Registry

SEC. 2521. NATIONAL MEDICAL DEVICE REGISTRY.

(a) REGISTRY.—

(1) IN GENERAL.—Section 519 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360i) is amended—

(A) by redesignating subsection (g) as subsection (h); and

(B) by inserting after subsection (f) the following:

''National Medical Device Registry

''(g)(1) The Secretary shall establish a national medical device registry (in this subsection referred to as the 'registry') to facilitate analysis of postmarket safety and outcomes data on each device that—

''(A) is or has been used in or on a patient; and

''(B) is—

''(i) a class III device; or

''(ii) a class II device that is implantable, life-supporting, or life-sustaining.

''(2) In developing the registry, the Secretary shall, in consultation with the Commissioner of Food and Drugs, the Administrator of the Centers for Medicare & Medicaid Services, the head of the Office of the National Coordinator for Health Information Technology, and the Secretary of Veterans Affairs, determine the best methods for—

''(A) including in the registry, in a manner consistent with subsection (f), appropriate information to identify each device described in paragraph (1) by type, model, and serial number or other unique identifier;

''(B) validating methods for analyzing patient safety and outcomes data from multiple sources and for linking such data with the information included in the registry as described in subparagraph (A), including, to the extent feasible, use of—

''(i) data provided to the Secretary under other provisions of this chapter; and

''(ii) information from public and private sources identified under paragraph (3);

''(C) integrating the activities described in this subsection with—

''(i) activities under paragraph (3) of section 505(k) (relating to active postmarket risk identification);

''(ii) activities under paragraph (4) of section 505(k) (relating to advanced analysis of drug safety data); and

''(iii) other postmarket device surveillance activities of the Secretary authorized by this chapter; and

''(D) providing public access to the data and analysis collected or developed through the registry in a manner and form that protects patient privacy and proprietary information and is comprehensive, useful, and not misleading to patients, physicians, and scientists.

''(3)(A) To facilitate analyses of postmarket safety and patient outcomes for devices described in paragraph (1), the Secretary shall, in collaboration with public, academic, and private entities, develop methods to—

''(i) obtain access to disparate sources of patient safety and outcomes data, including—

''(I) Federal health-related electronic data (such as data from the Medicare pro-

gram under title XVIII of the Social Security Act or from the health systems of the Department of Veterans Affairs);

''(II) private sector health-related electronic data (such as pharmaceutical purchase data and health insurance claims data); and

''(III) other data as the Secretary deems necessary to permit postmarket assessment of device safety and effectiveness; and

''(ii) link data obtained under clause (i) with information in the registry.

''(B) In this paragraph, the term 'data' refers to information respecting a device described in paragraph (1), including claims data, patient survey data, standardized analytic files that allow for the pooling and analysis of data from disparate data environments, electronic health records, and any other data deemed appropriate by the Secretary.

''(4) Not later than 36 months after the date of the enactment of this subsection, the Secretary shall promulgate regulations for establishment and operation of the registry under paragraph (1). Such regulations—

''(A)(i) in the case of devices that are described in paragraph (1) and sold on or after the date of the enactment of this subsection, shall require manufacturers of such devices to submit information to the registry, including, for each such device, the type, model, and serial number or, if required under subsection (f), other unique device identifier; and

''(ii) in the case of devices that are described in paragraph (1) and sold before such date, may require manufacturers of such devices to submit such information to the registry, if deemed necessary by the Secretary to protect the public health;

''(B) shall establish procedures—

''(i) to permit linkage of information submitted pursuant to subparagraph (A) with patient safety and outcomes data obtained under paragraph (3); and

''(ii) to permit analyses of linked data;

''(C) may require device manufacturers to submit such other information as is necessary to facilitate postmarket assessments of device safety and effectiveness and notification of device risks;

''(D) shall establish requirements for regular and timely reports to the Secretary, which shall be included in the registry, concerning adverse event

trends, adverse event patterns, incidence and prevalence of adverse events, and other information the Secretary determines appropriate, which may include data on comparative safety and outcomes trends; and

''(E) shall establish procedures to permit public access to the information in the registry in a manner and form that protects patient privacy and proprietary information and is comprehensive, useful, and not misleading to patients, physicians, and scientists.

''(5) To carry out this subsection, there are authorized to be appropriated such sums as may be necessary for fiscal years 2010 and 2011.''.

(2) EFFECTIVE DATE.—The Secretary of Health and Human Services shall establish and begin implementation of the registry under section 519(g) of the Federal Food, Drug, and Cosmetic Act, as added by paragraph (1), by not later than the date that is 36 months after the date of the enactment of this Act, without regard to whether or not final regulations to establish and operate the registry have been promulgated by such date.

(3) CONFORMING AMENDMENT.—Section 303(f)(1)(B)(ii) of the Federal Food, Drug, and

Cosmetic Act (21 U.S.C. 333(f)(1)(B)(ii)) is amended by striking ''519(g)'' and inserting ''519(h)''.

(b) ELECTRONIC EXCHANGE AND USE IN CERTIFIED ELECTRONIC HEALTH RECORDS OF UNIQUE DEVICE IDENTIFIERS.—

(1) RECOMMENDATIONS.—The HIT Policy Committee established under section 3002 of the Public Health Service Act (42 U.S.C. 300jj–12) shall recommend to the head of the Office of the National Coordinator for Health Information Technology standards, implementation specifications, and certification criteria for the electronic exchange and use in certified electronic health records of a unique device identifier for each device described in section 519(g)(1) of the Federal Food, Drug, and Cosmetic Act, as added by subsection (a).

(2) STANDARDS, IMPLEMENTATION CRITERIA, AND CERTIFICATION CRITERIA.—The Secretary of the Health Human Services, acting through the head of the Office of the National Coordinator for Health Information Technology, shall adopt standards, implementation specifications, and certification criteria for the electronic exchange and use in certified electronic health records of a unique device identifier for each device described in paragraph (1),

if such an identifier is required by section 519(f) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360i(f)) for the device.

Subtitle D—Grants for Comprehensive Programs to Provide Education to Nurses and Create a Pipeline to Nursing

SEC. 2531. ESTABLISHMENT OF GRANT PROGRAM.

(a) PURPOSES.—It is the purpose of this section to authorize grants to—

(1) address the projected shortage of nurses by funding comprehensive programs to create a career ladder to nursing (including Certified Nurse Assistants, Licensed Practical Nurses, Licensed Vocational Nurses, and Registered Nurses) for incumbent ancillary health care workers;

(2) increase the capacity for educating nurses by increasing both nurse faculty and clinical opportunities through collaborative programs between staff nurse organizations, health care providers, and accredited schools of nursing; and

(3) provide training programs through education and training organizations jointly administered by health care providers and health care labor organizations or other organizations representing

staff nurses and frontline health care workers, working in collaboration with accredited schools of nursing and academic institutions.

(b) GRANTS.—Not later than 6 months after the date of the enactment of this Act, the Secretary of Labor (referred to in this section as the ''Secretary'') shall establish a partnership grant program to award grants to eligible entities to carry out comprehensive programs to provide education to nurses and create a pipeline to nursing for incumbent ancillary health care workers who wish to advance their careers, and to otherwise carry out the purposes of this section.

(c) ELIGIBILITY.—To be eligible for a grant under this section, an entity shall be—

(1) a health care entity that is jointly administered by a health care employer and a labor union representing the health care employees of the employer and that carries out activities using labor management training funds as provided for under section 302(c)(6) of the Labor Management Relations Act, 1947 (29 U.S.C. 186(c)(6));

(2) an entity that operates a training program that is jointly administered by—

(A) one or more health care providers or facilities, or a trade association of health care providers; and

(B) one or more organizations which represent the interests of direct care health care workers or staff nurses and in which the direct care health care workers or staff nurses have direct input as to the leadership of the organization;

(3) a State training partnership program that consists of nonprofit organizations that include equal participation from industry, including public or private employers, and labor organizations including joint labor-management training programs, and which may include representatives from local governments, worker investment agency one-stop career centers, community-based organizations, community colleges, and accredited schools of nursing; or

(4) a school of nursing (as defined in section 801 of the Public Health Service Act (42 U.S.C. 296)).

(d) ADDITIONAL REQUIREMENTS FOR HEALTH CARE EMPLOYER DESCRIBED IN SUBSECTION (c).—To be eligible for a grant under this section, a health care employer described in subsection (c) shall demonstrate that it—

(1) has an established program within their facility to encourage the retention of existing nurses;

(2) provides wages and benefits to its nurses that are competitive for its market or that have been collectively bargained with a labor organization; and

(3) supports programs funded under this section through 1 or more of the following:

(A) The provision of paid leave time and continued health coverage to incumbent health care workers to allow their participation in nursing career ladder programs, including certified nurse assistants, licensed practical nurses, licensed vocational nurses, and registered nurses.

(B) Contributions to a joint labor-management training fund which administers the program involved.

(C) The provision of paid release time, incentive compensation, or continued health coverage to staff nurses who desire to work full- or part-time in a faculty position.

(D) The provision of paid release time for staff nurses to enable them to obtain a bachelor of science in nursing degree, other advanced

nursing degrees, specialty training, or certification program.

(E) The payment of tuition assistance which is managed by a joint labor-management training fund or other jointly administered program.

(e) OTHER REQUIREMENTS.—

(1) MATCHING REQUIREMENT.—

(A) IN GENERAL.—The Secretary may not make a grant under this section unless the applicant involved agrees, with respect to the costs to be incurred by the applicant in carrying out the program under the grant, to make available non-Federal contributions (in cash or in kind under subparagraph (B)) toward such costs in an amount equal to not less than $1 for each $1 of Federal funds provided in the grant. Such contributions may be made directly or through donations from public or private entities, or may be provided through the cash equivalent of paid release time provided to incumbent worker students.

(B) DETERMINATION OF AMOUNT OF NON-FEDERAL CONTRIBUTION.—Non-Federal contributions required in subparagraph (A) may be

in cash or in kind (including paid release time), fairly evaluated, including equipment or services (and excluding indirect or overhead costs). Amounts provided by the Federal Government, or services assisted or subsidized to any significant extent by the Federal Government, may not be included in determining the amount of such non-Federal contributions.

(2) REQUIRED COLLABORATION.—Entities carrying out or overseeing programs carried out with assistance provided under this section shall demonstrate collaboration with accredited schools of nursing which may include community colleges and other academic institutions providing associate, bachelor's, or advanced nursing degree programs or specialty training or certification programs.

(f) USE OF FUNDS.—Amounts awarded to an entity under a grant under this section shall be used for the following:

(1) To carry out programs that provide education and training to establish nursing career ladders to educate incumbent health care workers to become nurses (including certified nurse assistants, licensed practical nurses, licensed vocational nurses,

and registered nurses). Such programs shall include one or more of the following:

(A) Preparing incumbent workers to return to the classroom through English -as-a-second language education, GED education, pre-college counseling, college preparation classes, and support with entry level college classes that are a prerequisite to nursing.

(B) Providing tuition assistance with preference for dedicated cohort classes in community colleges, universities, accredited schools of nursing with supportive services including tutoring and counseling.

(C) Providing assistance in preparing for and meeting all nursing licensure tests and requirements.

(D) Carrying out orientation and mentorship programs that assist newly graduated nurses in adjusting to working at the bedside to ensure their retention postgraduation, and ongoing programs to support nurse retention.

(E) Providing stipends for release time and continued health care coverage to enable incum-

bent health care workers to participate in these programs.

(2) To carry out programs that assist nurses in obtaining advanced degrees and completing specialty training or certification programs and to establish incentives for nurses to assume nurse faculty positions on a part-time or full-time basis. Such programs shall include one or more of the following:

(A) Increasing the pool of nurses with advanced degrees who are interested in teaching by funding programs that enable incumbent nurses to return to school.

(B) Establishing incentives for advanced degree bedside nurses who wish to teach in nursing programs so they can obtain a leave from their bedside position to assume a full- or part-time position as adjunct or full-time faculty without the loss of salary or benefits.

(C) Collaboration with accredited schools of nursing which may include community colleges and other academic institutions providing associate, bachelor's, or advanced nursing degree programs, or specialty training or certification programs, for nurses to carry out innova-

tive nursing programs which meet the needs of bedside nursing and health care providers.

(g) PREFERENCE.—In awarding grants under this section the Secretary shall give preference to programs that—

(1) provide for improving nurse retention;

(2) provide for improving the diversity of the new nurse graduates to reflect changes in the demographics of the patient population;

(3) provide for improving the quality of nursing education to improve patient care and safety;

(4) have demonstrated success in upgrading incumbent health care workers to become nurses or which have established effective programs or pilots to increase nurse faculty; or

(5) are modeled after or affiliated with such programs described in paragraph (4).

(h) EVALUATION.—

(1) PROGRAM EVALUATIONS.—An entity that receives a grant under this section shall annually evaluate, and submit to the Secretary a report on, the activities carried out under the grant and the outcomes of such activities. Such outcomes may include—

(A) an increased number of incumbent workers entering an accredited school of nursing and in the pipeline for nursing programs;

(B) an increasing number of graduating nurses and improved nurse graduation and licensure rates;

(C) improved nurse retention;

(D) an increase in the number of staff nurses at the health care facility involved;

(E) an increase in the number of nurses with advanced degrees in nursing;

(F) an increase in the number of nurse faculty;

(G) improved measures of patient quality (which may include staffing ratios of nurses, patient satisfaction rates, patient safety measures); and

(H) an increase in the diversity of new nurse graduates relative to the patient population.

(2) GENERAL REPORT.—Not later than 2 years after the date of the enactment of this Act, and annually thereafter, the Secretary of Labor shall, using data and information from the reports received under paragraph (1), submit to the Congress a re-

port concerning the overall effectiveness of the grant program carried out under this section.

(i) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section such sums as may be necessary.

Subtitle E—States Failing to Adhere to Certain Employment Obligations

SEC. 2541. LIMITATION ON FEDERAL FUNDS.

A State is eligible for Federal funds under the provisions of the Public Health Service Act (42 U.S.C. 201 et seq.) only if the State—

(1) agrees to be subject in its capacity as an employer to each obligation under division A of this Act and the amendments made by such division applicable to persons in their capacity as an employer; and

(2) assures that all political subdivisions in the State will do the same.