AMENDMENT IN THE NATURE OF A SUBSTITUTE TO H.R. 3200

OFFERED BY MR. RANGEL OF NEW YORK

Strike all after the enacting clause and insert the following:

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

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

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

DIVISION I—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 [*TEXT OMITTED BECAUSE OUTSIDE JURISDICTION OF COMMITTEE ON WAYS AND MEANS*]

TITLE VIII—REVENUE-RELATED PROVISIONS

TITLE IX—MISCELLANEOUS PROVISIONS

DIVISION C—PUBLIC HEALTH AND WORKFORCE DEVELOPMENT [*TEXT OMITTED BECAUSE OUTSIDE JURISDICTION OF COMMITTEE ON WAYS AND MEANS*]

1 # DIVISION I—AFFORDABLE
2 # HEALTH CARE CHOICES

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

5 (a) PURPOSE.—
6 (1) IN GENERAL.—The purpose of this division
7 is to provide affordable, quality health care for all
8 Americans and reduce the growth in health care
9 spending.
10 (2) BUILDING ON CURRENT SYSTEM.—This di-
11 vision achieves this purpose by building on what
12 works in today's health care system, while repairing
13 the aspects that are broken.
14 (3) INSURANCE REFORMS.—This division—
15 (A) enacts strong insurance market re-
16 forms;

1 (B) creates a new Health Insurance Ex-
2 change, with a public health insurance option
3 alongside private plans;
4 (C) includes sliding scale affordability
5 credits; and
6 (D) initiates shared responsibility among
7 workers, employers, and the government;
8 so that all Americans have coverage of essential
9 health benefits.
10 (4) HEALTH DELIVERY REFORM.—This division
11 institutes health delivery system reforms both to in-
12 crease quality and to reduce growth in health spend-
13 ing so that health care becomes more affordable for
14 businesses, families, and government.
15 (b) TABLE OF CONTENTS OF DIVISION.—The table
16 of contents of this division is as follows:

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

TITLE I—PROTECTIONS AND STANDARDS FOR QUALIFIED HEALTH BENEFITS PLANS

Subtitle A—General Standards

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

Subtitle B—Standards Guaranteeing Access to Affordable Coverage

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

Subtitle C—Standards Guaranteeing Access to Essential Benefits

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

Subtitle D—Additional Consumer Protections

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

Subtitle E—Governance

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

Subtitle F—Relation to Other Requirements; Miscellaneous

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

Subtitle G—Early Investments

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

TITLE II—HEALTH INSURANCE EXCHANGE AND RELATED PROVISIONS

Subtitle A—Health Insurance Exchange

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

Subtitle B—Public Health Insurance Option

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

Subtitle C—Individual Affordability Credits

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

TITLE III—SHARED RESPONSIBILITY

Subtitle A—Individual Responsibility

Sec. 301. Individual responsibility.

Subtitle B—Employer Responsibility

PART 1—HEALTH COVERAGE PARTICIPATION REQUIREMENTS

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

PART 2—SATISFACTION OF HEALTH COVERAGE PARTICIPATION REQUIREMENTS

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

TITLE IV—AMENDMENTS TO INTERNAL REVENUE CODE OF 1986

Subtitle A—Shared Responsibility

PART 1—INDIVIDUAL RESPONSIBILITY

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

PART 2—EMPLOYER RESPONSIBILITY

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

Subtitle B—Credit for Small Business Employee Health Coverage Expenses

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

Subtitle C—Disclosures to Carry Out Health Insurance Exchange Subsidies

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

Subtitle D—Other Revenue Provisions

PART 1—GENERAL PROVISIONS

Sec. 441. Surcharge on high income individuals.
Sec. 442. Distributions for medicine qualified only if for prescribed drug or insulin.
Sec. 443. Delay in application of worldwide allocation of interest.

PART 2—PREVENTION OF TAX AVOIDANCE

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

PART 3—PARITY IN HEALTH BENEFITS

Sec. 461. Certain health related benefits applicable to spouses and dependents extended to eligible beneficiaries.

1 (c) GENERAL DEFINITIONS.—Except as otherwise
2 provided, in this division:
3 (1) ACCEPTABLE COVERAGE.—The term ''ac-
4 ceptable coverage'' has the meaning given such term
5 in section 202(d)(2).
6 (2) BASIC PLAN.—The term ''basic plan'' has
7 the meaning given such term in section 203(c).
8 (3) COMMISSIONER.—The term ''Commis-
9 sioner'' means the Health Choices Commissioner es-
10 tablished under section 141.
11 (4) COST-SHARING.—The term ''cost-sharing''
12 includes deductibles, coinsurance, copayments, and
13 similar charges but does not include premiums or
14 any network payment differential for covered serv-
15 ices or spending for non-covered services.

1 (5) DEPENDENT.—The term ''dependent'' has
2 the meaning given such term by the Commissioner
3 and includes a spouse.
4 (6) EMPLOYMENT-BASED HEALTH PLAN.—The
5 term ''employment-based health plan''—
6 (A) means a group health plan (as defined
7 in section 733(a)(1) of the Employee Retire-
8 ment Income Security Act of 1974); and
9 (B) includes such a plan that is the fol-
10 lowing:
11 (i) FEDERAL, STATE, AND TRIBAL
12 GOVERNMENTAL PLANS.—A governmental
13 plan (as defined in section 3(32) of the
14 Employee Retirement Income Security Act
15 of 1974), including a health benefits plan
16 offered under chapter 89 of title 5, United
17 States Code.
18 (ii) CHURCH PLANS.—A church plan
19 (as defined in section 3(33) of the Em-
20 ployee Retirement Income Security Act of
21 1974).
22 (7) ENHANCED PLAN.—The term ''enhanced
23 plan'' has the meaning given such term in section
24 203(c).

1 (8) ESSENTIAL BENEFITS PACKAGE.—The term
2 ''essential benefits package'' is defined in section
3 122(a).
4 (9) FAMILY.—The term ''family'' means an in-
5 dividual and includes the individual's dependents.
6 (10) FEDERAL POVERTY LEVEL; FPL.—The
7 terms ''Federal poverty level'' and ''FPL'' have the
8 meaning given the term ''poverty line'' in section
9 673(2) of the Community Services Block Grant Act
10 (42 U.S.C. 9902(2)), including any revision required
11 by such section.
12 (11) HEALTH BENEFITS PLAN.—The terms
13 ''health benefits plan'' means health insurance cov-
14 erage and an employment-based health plan and in-
15 cludes the public health insurance option.
16 (12) HEALTH INSURANCE COVERAGE; HEALTH
17 INSURANCE ISSUER.—The terms ''health insurance
18 coverage'' and ''health insurance issuer'' have the
19 meanings given such terms in section 2791 of the
20 Public Health Service Act.
21 (13) HEALTH INSURANCE EXCHANGE.—The
22 term ''Health Insurance Exchange'' means the
23 Health Insurance Exchange established under sec-
24 tion 201.

1 (14) MEDICAID.—The term ''Medicaid'' means
2 a State plan under title XIX of the Social Security
3 Act (whether or not the plan is operating under a
4 waiver under section 1115 of such Act).
5 (15) MEDICARE.—The term ''Medicare'' means
6 the health insurance programs under title XVIII of
7 the Social Security Act.
8 (16) PLAN SPONSOR.—The term ''plan spon-
9 sor'' has the meaning given such term in section
10 3(16)(B) of the Employee Retirement Income Secu-
11 rity Act of 1974.
12 (17) PLAN YEAR.—The term ''plan year''
13 means—
14 (A) with respect to an employment-based
15 health plan, a plan year as specified under such
16 plan; or
17 (B) with respect to a health benefits plan
18 other than an employment-based health plan, a
19 12-month period as specified by the Commis-
20 sioner.
21 (18) PREMIUM PLAN; PREMIUM-PLUS PLAN.—
22 The terms ''premium plan'' and ''premium-plus
23 plan'' have the meanings given such terms in section
24 203(c).

1 (19) QHBP OFFERING ENTITY.—The terms
2 ‘‘QHBP offering entity’’ means, with respect to a
3 health benefits plan that is—
4 (A) a group health plan (as defined, sub-
5 ject to subsection (d), in section 733(a)(1) of
6 the Employee Retirement Income Security Act
7 of 1974), the plan sponsor in relation to such
8 group health plan, except that, in the case of a
9 plan maintained jointly by 1 or more employers
10 and 1 or more employee organizations and with
11 respect to which an employer is the primary
12 source of financing, such term means such em-
13 ployer;
14 (B) health insurance coverage, the health
15 insurance issuer offering the coverage;
16 (C) the public health insurance option, the
17 Secretary of Health and Human Services;
18 (D) a non-Federal governmental plan (as
19 defined in section 2791(d) of the Public Health
20 Service Act), the State or political subdivision
21 of a State (or agency or instrumentality of such
22 State or subdivision) which establishes or main-
23 tains such plan; or

1 (E) a Federal governmental plan (as de-
2 fined in section 2791(d) of the Public Health
3 Service Act), the appropriate Federal official.
4 (20) QUALIFIED HEALTH BENEFITS PLAN.—
5 The term ''qualified health benefits plan'' means a
6 health benefits plan that meets the requirements for
7 such a plan under title I and includes the public
8 health insurance option.
9 (21) PUBLIC HEALTH INSURANCE OPTION.—
10 The term ''public health insurance option'' means
11 the public health insurance option as provided under
12 subtitle B of title II.
13 (22) SERVICE AREA; PREMIUM RATING AREA.—
14 The terms ''service area'' and ''premium rating
15 area'' mean with respect to health insurance cov-
16 erage—
17 (A) offered other than through the Health
18 Insurance Exchange, such an area as estab-
19 lished by the QHBP offering entity of such cov-
20 erage in accordance with applicable State law;
21 and
22 (B) offered through the Health Insurance
23 Exchange, such an area as established by such
24 entity in accordance with applicable State law

1 and applicable rules of the Commissioner for
2 Exchange-participating health benefits plans.
3 (23) STATE.—The term ''State'' means the 50
4 States and the District of Columbia.
5 (24) STATE MEDICAID AGENCY.—The term
6 ''State Medicaid agency'' means, with respect to a
7 Medicaid plan, the single State agency responsible
8 for administering such plan under title XIX of the
9 Social Security Act.
10 (25) Y1, Y2, ETC..—The terms ''Y1'' , ''Y2'',
11 ''Y3'', ''Y4'', ''Y5'', and similar subsequently num-
12 bered terms, mean 2013 and subsequent years, re-
13 spectively.

14 TITLE I—PROTECTIONS AND 15 STANDARDS FOR QUALIFIED 16 HEALTH BENEFITS PLANS

17 Subtitle A—General Standards

18 SEC. 101. REQUIREMENTS REFORMING HEALTH INSUR- 19 ANCE MARKETPLACE.

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

1 (b) REQUIREMENTS FOR QUALIFIED HEALTH BENE-
2 FITS PLANS.—On or after the first day of Y1, a health
3 benefits plan shall not be a qualified health benefits plan
4 under this division unless the plan meets the applicable
5 requirements of the following subtitles for the type of plan
6 and plan year involved:
7 (1) Subtitle B (relating to affordable coverage).
8 (2) Subtitle C (relating to essential benefits).
9 (3) Subtitle D (relating to consumer protec-
10 tion).
11 (c) TERMINOLOGY.—In this division:
12 (1) ENROLLMENT IN EMPLOYMENT-BASED
13 HEALTH PLANS.—An individual shall be treated as
14 being ''enrolled'' in an employment-based health
15 plan if the individual is a participant or beneficiary
16 (as such terms are defined in section 3(7) and 3(8),
17 respectively, of the Employee Retirement Income Se-
18 curity Act of 1974) in such plan.
19 (2) INDIVIDUAL AND GROUP HEALTH INSUR-
20 ANCE COVERAGE.—The terms ''individual health in-
21 surance coverage'' and ''group health insurance cov-
22 erage'' mean health insurance coverage offered in
23 the individual market or large or small group mar-
24 ket, respectively, as defined in section 2791 of the
25 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.

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

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

10 (1) GRACE PERIOD.—

11 (A) IN GENERAL.—The Commissioner
12 shall establish a grace period whereby, for plan
13 years beginning after the end of the 5-year pe-
14 riod beginning with Y1, an employment-based
15 health plan in operation as of the day before
16 the first day of Y1 must meet the same require-
17 ments as apply to a qualified health benefits
18 plan under section 101, including the essential
19 benefit package requirement under section 121.

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

1 (i) Any coverage described in section
2 3001(a)(1)(B)(ii)(IV) of division B of the
3 American Recovery and Reinvestment Act
4 of 2009 (PL 111–5).
5 (ii) Excepted benefits (as defined in
6 section 733(c) of the Employee Retirement
7 Income Security Act of 1974), including
8 coverage under a specified disease or ill-
9 ness policy described in paragraph (3)(A)
10 of such section.
11 (iii) Such other limited benefits as the
12 Commissioner may specify.
13 In no case shall an employment-based health
14 plan in which the coverage consists only of one
15 or more of the coverage or benefits described in
16 clauses (i) through (iii) be treated as acceptable
17 coverage under this division
18 (2) TRANSITIONAL TREATMENT AS ACCEPT-
19 ABLE COVERAGE.—During the grace period specified
20 in paragraph (1)(A), an employment-based health
21 plan that is described in such paragraph shall be
22 treated as acceptable coverage under this division.
23 (c) LIMITATION ON INDIVIDUAL HEALTH INSURANCE
24 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.

1 **SEC. 113. INSURANCE RATING RULES.**

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

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

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

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

22 (b) STUDY AND REPORTS.—

23 (1) STUDY.—The Commissioner, in coordina-
24 tion with the Secretary of Health and Human Serv-
25 ices and the Secretary of Labor, shall conduct a
26 study of the large group insured and self-insured

1 employer health care markets. Such study shall ex-
2 amine the following:
3 (A) The types of employers by key charac-
4 teristics, including size, that purchase insured
5 products versus those that self-insure.
6 (B) The similarities and differences be-
7 tween typical insured and self-insured health
8 plans.
9 (C) The financial solvency and capital re-
10 serve levels of employers that self-insure by em-
11 ployer size.
12 (D) The risk of self-insured employers not
13 being able to pay obligations or otherwise be-
14 coming financially insolvent.
15 (E) The extent to which rating rules are
16 likely to cause adverse selection in the large
17 group market or to encourage small and mid
18 size employers to self-insure
19 (2) REPORTS.—Not later than 18 months after
20 the date of the enactment of this Act, the Commis-
21 sioner shall submit to Congress and the applicable
22 agencies a report on the study conducted under
23 paragraph (1). Such report shall include any rec-
24 ommendations the Commissioner deems appropriate
25 to ensure that the law does not provide incentives

1 for small and mid-size employers to self-insure or
2 create adverse selection in the risk pools of large
3 group insurers and self-insured employers. Not later
4 than 18 months after the first day of Y1, the Com-
5 missioner shall submit to Congress and the applica-
6 ble agencies an updated report on such study, in-
7 cluding updates on such recommendations.

8 **SEC. 114. NONDISCRIMINATION IN BENEFITS; PARITY IN**
9 **MENTAL HEALTH AND SUBSTANCE ABUSE**
10 **DISORDER BENEFITS.**

11 (a) NONDISCRIMINATION IN BENEFITS.—A qualified
12 health benefits plan shall comply with standards estab-
13 lished by the Commissioner to prohibit discrimination in
14 health benefits or benefit structures for qualifying health
15 benefits plans, building from sections 702 of Employee
16 Retirement Income Security Act of 1974, 2702 of the
17 Public Health Service Act, and section 9802 of the Inter-
18 nal Revenue Code of 1986.

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

1 vidual or group market, in the same manner as such provi-
2 sions apply to health insurance coverage offered in the
3 large group market.

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

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

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

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

18 (a) IN GENERAL.—A qualified health benefits plan
19 shall meet a medical loss ratio as defined by the Commis-
20 sioner. For any plan year in which the qualified health
21 benefits plan does not meet such medical loss ratio, QHBP
22 offering entity shall provide in a manner specified by the
23 Commissioner for rebates to enrollees of payment suffi-
24 cient to meet such loss ratio.

1 (b) BUILDING ON INTERIM RULES.—In imple-
2 menting subsection (a), the Commissioner shall build on
3 the definition and methodology developed by the Secretary
4 of Health and Human Services under the amendments
5 made by section 161 for determining how to calculate the
6 medical loss ratio. Such methodology shall be set at the
7 highest level medical loss ratio possible that is designed
8 to ensure adequate participation by QHBP offering enti-
9 ties, competition in the health insurance market in and
10 out of the Health Insurance Exchange, and value for con-
11 sumers so that their premiums are used for services.

12 Subtitle C—Standards Guaran-
13 teeing Access to Essential Bene-
14 fits

15 SEC. 121. COVERAGE OF ESSENTIAL BENEFITS PACKAGE.

16 (a) IN GENERAL.—A qualified health benefits plan
17 shall provide coverage that at least meets the benefit
18 standards adopted under section 124 for the essential ben-
19 efits package described in section 122 for the plan year
20 involved.
21 (b) CHOICE OF COVERAGE.—
22 (1) NON-EXCHANGE-PARTICIPATING HEALTH
23 BENEFITS PLANS.—In the case of a qualified health
24 benefits plan that is not an Exchange-participating
25 health benefits plan, such plan may offer such cov-

1 erage in addition to the essential benefits package as
2 the QHBP offering entity may specify.
3 (2) EXCHANGE-PARTICIPATING HEALTH BENE-
4 FITS PLANS.—In the case of an Exchange-partici-
5 pating health benefits plan, such plan is required
6 under section 203 to provide specified levels of bene-
7 fits and, in the case of a plan offering a premium-
8 plus level of benefits, provide additional benefits.
9 (3) CONTINUATION OF OFFERING OF SEPARATE
10 EXCEPTED BENEFITS COVERAGE.—Nothing in this
11 division shall be construed as affecting the offering
12 of health benefits in the form of excepted benefits
13 (described in section 102(b)(1)(B)(ii)) if such bene-
14 fits are offered under a separate policy, contract, or
15 certificate of insurance.
16 (c) NO RESTRICTIONS ON COVERAGE UNRELATED
17 TO CLINICAL APPROPRIATENESS.—A qualified health ben-
18 efits plan may not impose any restriction (other than cost-
19 sharing) unrelated to clinical appropriateness on the cov-
20 erage of the health care items and services.

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

22 (a) IN GENERAL.—In this division, the term ''essen-
23 tial benefits package'' means health benefits coverage,
24 consistent with standards adopted under section 124 to

1 ensure the provision of quality health care and financial
2 security, that—
3 (1) provides payment for the items and services
4 described in subsection (b) in accordance with gen-
5 erally accepted standards of medical or other appro-
6 priate clinical or professional practice;
7 (2) limits cost-sharing for such covered health
8 care items and services in accordance with such ben-
9 efit standards, consistent with subsection (c);
10 (3) does not impose any annual or lifetime limit
11 on the coverage of covered health care items and
12 services;
13 (4) complies with section 115(a) (relating to
14 network adequacy); and
15 (5) is equivalent, as certified by Office of the
16 Actuary of the Centers for Medicare & Medicaid
17 Services, to the average prevailing employer-spon-
18 sored coverage.
19 (b) MINIMUM SERVICES TO BE COVERED.—The
20 items and services described in this subsection are the fol-
21 lowing:
22 (1) Hospitalization.
23 (2) Outpatient hospital and outpatient clinic
24 services, including emergency department services.

1 (3) Professional services of physicians and other
2 health professionals.
3 (4) Such services, equipment, and supplies inci-
4 dent to the services of a physician's or a health pro-
5 fessional's delivery of care in institutional settings,
6 physician offices, patients' homes or place of resi-
7 dence, or other settings, as appropriate.
8 (5) Prescription drugs.
9 (6) Rehabilitative and habilitative services.
10 (7) Mental health and substance use disorder
11 services.
12 (8) Preventive services, including those services
13 recommended with a grade of A or B by the Task
14 Force on Clinical Preventive Services and those vac-
15 cines recommended for use by the Director of the
16 Centers for Disease Control and Prevention.
17 (9) Maternity care.
18 (10) Well baby and well child care and oral
19 health, vision, and hearing services, equipment, and
20 supplies at least for children under 21 years of age.
21 (c) REQUIREMENTS RELATING TO COST-SHARING
22 AND MINIMUM ACTUARIAL VALUE.—
23 (1) NO COST-SHARING FOR PREVENTIVE SERV-
24 ICES.—There shall be no cost-sharing under the es-
25 sential benefits package for preventive items and

1 services (as specified under the benefit standards),
2 including well baby and well child care.
3 (2) ANNUAL LIMITATION.—
4 (A) ANNUAL LIMITATION.—The cost-shar-
5 ing incurred under the essential benefits pack-
6 age with respect to an individual (or family) for
7 a year does not exceed the applicable level spec-
8 ified in subparagraph (B).
9 (B) APPLICABLE LEVEL.—The applicable
10 level specified in this subparagraph for Y1 is
11 $5,000 for an individual and $10,000 for a
12 family. Such levels shall be increased (rounded
13 to the nearest $100) for each subsequent year
14 by the annual percentage increase in the Con-
15 sumer Price Index (United States city average)
16 applicable to such year.
17 (C) USE OF COPAYMENTS.—In establishing
18 cost-sharing levels for basic, enhanced, and pre-
19 mium plans under this subsection, the Sec-
20 retary shall, to the maximum extent possible,
21 use only copayments and not coinsurance.
22 (3) MINIMUM ACTUARIAL VALUE.—
23 (A) IN GENERAL.—The cost-sharing under
24 the essential benefits package shall be designed
25 to provide a level of coverage that is designed

1 to provide benefits that are actuarially equiva-
2 lent to approximately 70 percent of the full ac-
3 tuarial value of the benefits provided under the
4 reference benefits package described in sub-
5 paragraph (B).

6 (B) REFERENCE BENEFITS PACKAGE DE-
7 SCRIBED.—The reference benefits package de-
8 scribed in this subparagraph is the essential
9 benefits package if there were no cost-sharing
10 imposed.

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

12 (a) ESTABLISHMENT.—

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

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

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

1 (A) 9 members who are not Federal em-
2 ployees or officers and who are appointed by
3 the President.
4 (B) 9 members who are not Federal em-
5 ployees or officers and who are appointed by
6 the Comptroller General of the United States in
7 a manner similar to the manner in which the
8 Comptroller General appoints members to the
9 Medicare Payment Advisory Commission under
10 section 1805(c) of the Social Security Act.
11 (C) Such even number of members (not to
12 exceed 8) who are Federal employees and offi-
13 cers, as the President may appoint.
14 Such initial appointments shall be made not later
15 than 60 days after the date of the enactment of this
16 Act.
17 (4) TERMS.—Each member of the Health Bene-
18 fits Advisory Committee shall serve a 3-year term on
19 the Committee, except that the terms of the initial
20 members shall be adjusted in order to provide for a
21 staggered term of appointment for all such mem-
22 bers.
23 (5) PARTICIPATION.—The membership of the
24 Health Benefits Advisory Committee shall at least
25 reflect providers, consumer representatives, employ-

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

11 (b) DUTIES.—

12 (1) RECOMMENDATIONS ON BENEFIT STAND-
13 ARDS.—The Health Benefits Advisory Committee
14 shall recommend to the Secretary of Health and
15 Human Services (in this subtitle referred to as the
16 "Secretary") benefit standards (as defined in para-
17 graph (4)), and periodic updates to such standards.
18 In developing such recommendations, the Committee
19 shall take into account innovation in health care and
20 consider how such standards could reduce health dis-
21 parities.

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

1 (3) PUBLIC INPUT.—The Health Benefits Advi-
2 sory Committee shall allow for public input as a part
3 of developing recommendations under this sub-
4 section.
5 (4) BENEFIT STANDARDS DEFINED.—In this
6 subtitle, the term "benefit standards" means stand-
7 ards respecting—
8 (A) the essential benefits package de-
9 scribed in section 122, including categories of
10 covered treatments, items and services within
11 benefit classes, and cost-sharing; and
12 (B) the cost-sharing levels for enhanced
13 plans and premium plans (as provided under
14 section 203(c)) consistent with paragraph (5).
15 (5) LEVELS OF COST-SHARING FOR ENHANCED
16 AND PREMIUM PLANS.—
17 (A) ENHANCED PLAN.—The level of cost-
18 sharing for enhanced plans shall be designed so
19 that such plans have benefits that are actuari-
20 ally equivalent to approximately 85 percent of
21 the actuarial value of the benefits provided
22 under the reference benefits package described
23 in section 122(c)(3)(B).
24 (B) PREMIUM PLAN.—The level of cost-
25 sharing for premium plans shall be designed so

1 that such plans have benefits that are actuari-
2 ally equivalent to approximately 95 percent of
3 the actuarial value of the benefits provided
4 under the reference benefits package described
5 in section 122(c)(3)(B).
6 (c) OPERATIONS.—
7 (1) PER DIEM PAY.—Each member of the
8 Health Benefits Advisory Committee shall receive
9 travel expenses, including per diem in accordance
10 with applicable provisions under subchapter I of
11 chapter 57 of title 5, United States Code, and shall
12 otherwise serve without additional pay.
13 (2) MEMBERS NOT TREATED AS FEDERAL EM-
14 PLOYEES.—Members of the Health Benefits Advi-
15 sory Committee shall not be considered employees of
16 the Federal government solely by reason of any serv-
17 ice on the Committee.
18 (3) APPLICATION OF FACA.—The Federal Advi-
19 sory Committee Act (5 U.S.C. App.), other than sec-
20 tion 14, shall apply to the Health Benefits Advisory
21 Committee.
22 (d) PUBLICATION.—The Secretary shall provide for
23 publication in the Federal Register and the posting on the
24 Internet website of the Department of Health and Human

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

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

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

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

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

16 (A) to propose adoption of benefit stand-
17 ards so recommended as a package, the Sec-
18 retary shall, by regulation under section 553 of
19 title 5, United States Code, propose adoption
20 such standards; or

21 (B) not to propose adoption of such stand-
22 ards as a package, the Secretary shall notify
23 the Health Benefits Advisory Committee in
24 writing of such determination and the reasons
25 for not proposing the adoption of such rec-

1 ommendation and provide the Committee with a
2 further opportunity to modify its previous rec-
3 ommendations and submit new recommenda-
4 tions to the Secretary on a timely basis.
5 (3) CONTINGENCY.—If, because of the applica-
6 tion of paragraph (2)(B), the Secretary would other-
7 wise be unable to propose initial adoption of such
8 recommended standards by the deadline specified in
9 subsection (b)(1), the Secretary shall, by regulation
10 under section 553 of title 5, United States Code,
11 propose adoption of initial benefit standards by such
12 deadline.
13 (4) PUBLICATION.—The Secretary shall provide
14 for publication in the Federal Register of all deter-
15 minations made by the Secretary under this sub-
16 section.
17 (b) ADOPTION OF STANDARDS.—
18 (1) INITIAL STANDARDS.—Not later than 18
19 months after the date of the enactment of this Act,
20 the Secretary shall, through the rulemaking process
21 consistent with subsection (a), adopt an initial set of
22 benefit standards.
23 (2) PERIODIC UPDATING STANDARDS.—Under
24 subsection (a), the Secretary shall provide for the

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

1 of plan documents, plan terms and conditions,
2 claims payment policies and practices, periodic fi-
3 nancial disclosure, data on enrollment, data on
4 disenrollment, data on the number of claims denials,
5 data on rating practices, information on cost-sharing
6 and payments with respect to any out-of-network
7 coverage, and other information as determined ap-
8 propriate by the Commissioner. The Commissioner
9 shall require that such disclosure be provided in
10 plain language.
11 (2) PLAIN LANGUAGE.—In this subsection, the
12 term ''plain language'' means language that the in-
13 tended audience, including individuals with limited
14 English proficiency, can readily understand and use
15 because that language is clean, concise, well-orga-
16 nized, and follows other best practices of plain lan-
17 guage writing.
18 (3) GUIDANCE.—The Commissioner shall de-
19 velop and issue guidance on best practices of plain
20 language writing.
21 (b) CONTRACTING REIMBURSEMENT.—A qualified
22 health benefits plan shall comply with standards estab-
23 lished by the Commissioner to ensure transparency to each
24 health care provider relating to reimbursement arrange-
25 ments between such plan and such provider.

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

5 **SEC. 134. APPLICATION TO QUALIFIED HEALTH BENEFITS**
6 **PLANS NOT OFFERED THROUGH THE**
7 **HEALTH INSURANCE EXCHANGE.**

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

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

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

20 **SEC. 136. STANDARDIZED RULES FOR COORDINATION AND**
21 **SUBROGATION OF BENEFITS.**

22 The Commissioner shall establish standards for the
23 coordination and subrogation of benefits and reimburse-
24 ment of payments in cases involving individuals and mul-
25 tiple plan coverage.

1 **SEC. 137. APPLICATION OF ADMINISTRATIVE SIMPLIFICA-**
2 **TION.**

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

7 Subtitle E—Governance

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

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

14 (b) COMMISSIONER.—

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

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

1 sioner of Social Security and the Social Security Ad-
2 ministration.

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

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

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

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

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

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

21 (b) PROMOTING ACCOUNTABILITY.—

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

1 gardless of whether such accountability is with re-
2 spect to qualified health benefits plans offered
3 through the Health Insurance Exchange or outside
4 of such Exchange.
5 (2) COMPLIANCE EXAMINATION AND AUDITS.—
6 (A) IN GENERAL.—The commissioner
7 shall, in coordination with States, conduct au-
8 dits of qualified health benefits plan compliance
9 with Federal requirements. Such audits may
10 include random compliance audits and targeted
11 audits in response to complaints or other sus-
12 pected non-compliance.
13 (B) RECOUPMENT OF COSTS IN CONNEC-
14 TION WITH EXAMINATION AND AUDITS.—The
15 Commissioner is authorized to recoup from
16 qualified health benefits plans reimbursement
17 for the costs of such examinations and audit of
18 such QHBP offering entities.
19 (c) DATA COLLECTION.—The Commissioner shall
20 collect data for purposes of carrying out the Commis-
21 sioner's duties, including for purposes of promoting qual-
22 ity and value, protecting consumers, and addressing dis-
23 parities in health and health care and may share such data
24 with the Secretary of Health and Human Services.
25 (d) SANCTIONS AUTHORITY.—

1 (1) IN GENERAL.—In the case that the Com-
2 missioner determines that a QHBP offering entity
3 violates a requirement of this title, the Commis-
4 sioner may, in coordination with State insurance
5 regulators and the Secretary of Labor, provide, in
6 addition to any other remedies authorized by law,
7 for any of the remedies described in paragraph (2).
8 (2) REMEDIES.—The remedies described in this
9 paragraph, with respect to a qualified health benefits
10 plan offered by a QHBP offering entity, are—
11 (A) civil money penalties of not more than
12 the amount that would be applicable under
13 similar circumstances for similar violations
14 under section 1857(g) of the Social Security
15 Act;
16 (B) suspension of enrollment of individuals
17 under such plan after the date the Commis-
18 sioner notifies the entity of a determination
19 under paragraph (1) and until the Commis-
20 sioner is satisfied that the basis for such deter-
21 mination has been corrected and is not likely to
22 recur;
23 (C) in the case of an Exchange-partici-
24 pating health benefits plan, suspension of pay-
25 ment to the entity under the Health Insurance

1 Exchange for individuals enrolled in such plan
2 after the date the Commissioner notifies the en-
3 tity of a determination under paragraph (1)
4 and until the Secretary is satisfied that the
5 basis for such determination has been corrected
6 and is not likely to recur; or
7 (D) working with State insurance regu-
8 lators to terminate plans for repeated failure by
9 the offering entity to meet the requirements of
10 this title.
11 (e) STANDARD DEFINITIONS OF INSURANCE AND
12 MEDICAL TERMS.—The Commissioner shall provide for
13 the development of standards for the definitions of terms
14 used in health insurance coverage, including insurance-re-
15 lated terms.
16 (f) EFFICIENCY IN ADMINISTRATION.—The Commis-
17 sioner shall issue regulations for the effective and efficient
18 administration of the Health Insurance Exchange and af-
19 fordability credits under subtitle C, including, with respect
20 to the determination of eligibility for affordability credits,
21 the use of personnel who are employed in accordance with
22 the requirements of title 5, United States Code, to carry
23 out the duties of the Commissioner or, in the case of sec-
24 tions 208 and 241(b)(2), the use of State personnel who
25 are employed in accordance with standards prescribed by

1 the Office of Personnel Management pursuant to section
2 208 of the Intergovernmental Personnel Act of 1970 (42
3 U.S.C. 4728).

4 **SEC. 143. CONSULTATION AND COORDINATION.**

5 (a) CONSULTATION.—In carrying out the Commis-
6 sioner's duties under this division, the Commissioner, as
7 appropriate, shall consult with at least with the following:
8 (1) The National Association of Insurance
9 Commissioners, State attorneys general, and State
10 insurance regulators, including concerning the
11 standards for insured qualified health benefits plans
12 under this title and enforcement of such standards.
13 (2) Appropriate State agencies, specifically con-
14 cerning the administration of individual affordability
15 credits under subtitle C of title II and the offering
16 of Exchange-participating health benefits plans, to
17 Medicaid eligible individuals under subtitle A of such
18 title.
19 (3) Other appropriate Federal agencies.
20 (4) Indian tribes and tribal organizations.
21 (5) The National Association of Insurance
22 Commissioners for purposes of using model guide-
23 lines established by such association for purposes of
24 subtitles B and D.
25 (b) COORDINATION.—

1 (1) IN GENERAL.—In carrying out the func-
2 tions of the Commissioner, including with respect to
3 the enforcement of the provisions of this division,
4 the Commissioner shall work in coordination with
5 existing Federal and State entities to the maximum
6 extent feasible consistent with this division and in a
7 manner that prevents conflicts of interest in duties
8 and ensures effective enforcement.
9 (2) UNIFORM STANDARDS.—The Commissioner,
10 in coordination with such entities, shall seek to
11 achieve uniform standards that adequately protect
12 consumers in a manner that does not unreasonably
13 affect employers and insurers.

14 **SEC. 144. HEALTH INSURANCE OMBUDSMAN.**

15 (a) IN GENERAL.—The Commissioner shall appoint
16 within the Health Choices Administration a Qualified
17 Health Benefits Plan Ombudsman who shall have exper-
18 tise and experience in the fields of health care and edu-
19 cation of (and assistance to) individuals.
20 (b) DUTIES.—The Qualified Health Benefits Plan
21 Ombudsman shall, in a linguistically appropriate man-
22 ner—
23 (1) receive complaints, grievances, and requests
24 for information submitted by individuals;

1 (2) provide assistance with respect to com-
2 plaints, grievances, and requests referred to in para-
3 graph (1), including—
4 (A) helping individuals determine the rel-
5 evant information needed to seek an appeal of
6 a decision or determination;
7 (B) assistance to such individuals with any
8 problems arising from disenrollment from such
9 a plan;
10 (C) assistance to such individuals in choos-
11 ing a qualified health benefits plan in which to
12 enroll; and
13 (D) assistance to such individuals in pre-
14 senting information under subtitle C (relating
15 to affordability credits); and
16 (3) submit annual reports to Congress and the
17 Commissioner that describe the activities of the Om-
18 budsman and that include such recommendations for
19 improvement in the administration of this division as
20 the Ombudsman determines appropriate. The Om-
21 budsman shall not serve as an advocate for any in-
22 creases in payments or new coverage of services, but
23 may identify issues and problems in payment or cov-
24 erage 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 (1) IN GENERAL.—In the case of health insur-
2 ance coverage offered through the Health Insurance
3 Exchange—
4 (A) the requirements of this title do not
5 supercede any requirements (including require-
6 ments relating to genetic information non-
7 discrimination and mental health) applicable
8 under title XXVII of the Public Health Service
9 Act or under State law, except insofar as such
10 requirements prevent the application of a re-
11 quirement of this division, as determined by the
12 Commissioner; and
13 (B) individual rights and remedies under
14 State laws shall apply.
15 (2) CONSTRUCTION.—In the case of coverage
16 described in paragraph (1), nothing in such para-
17 graph shall be construed as preventing the applica-
18 tion of rights and remedies under State laws with
19 respect to any requirement referred to in paragraph
20 (1)(A).
21 **SEC. 152. PROHIBITING DISCRIMINATION IN HEALTH CARE.**
22 (a) IN GENERAL.—Except as otherwise explicitly per-
23 mitted by this Act and by subsequent regulations con-
24 sistent with this Act, all health care and related services
25 (including insurance coverage and public health activities)

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

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

15 **SEC. 153. WHISTLEBLOWER PROTECTION.**

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

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

1 any act or omission the employee reasonably believes
2 to be a violation of any provision of this Act or any
3 order, rule, or regulation promulgated under this
4 Act;
5 (2) testified or is about to testify in a pro-
6 ceeding concerning such violation;
7 (3) assisted or participated or is about to assist
8 or participate in such a proceeding; or
9 (4) objected to, or refused to participate in, any
10 activity, policy, practice, or assigned task that the
11 employee (or other such person) reasonably believed
12 to be in violation of any provision of this Act or any
13 order, rule, or regulation promulgated under this
14 Act.
15 (b) ENFORCEMENT ACTION.—An employee covered
16 by this section who alleges discrimination by an employer
17 in violation of subsection (a) may bring an action governed
18 by the rules, procedures, legal burdens of proof, and rem-
19 edies set forth in section 40(b) of the Consumer Product
20 Safety Act (15 U.S.C. 2087(b)).
21 (c) EMPLOYER DEFINED.—As used in this section,
22 the term ‘‘employer’’ means any person (including one or
23 more individuals, partnerships, associations, corporations,
24 trusts, professional membership organization including a
25 certification, disciplinary, or other professional body, unin-

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

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

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

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

15 **SEC. 155. SEVERABILITY.**

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

21 Subtitle G—Early Investments

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

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

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

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

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

20 (b) INDIVIDUAL HEALTH INSURANCE COVERAGE.—
21 Such title is further amended by inserting after section
22 2753 the following new section:

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

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

1 same manner as such provisions apply to health insurance
2 coverage offered in the small or large group market.''.
3 (c) IMMEDIATE IMPLEMENTATION.—The amend-
4 ments made by this section shall apply in the group and
5 individual market for plan years beginning on or after
6 January 1, 2011.

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

8 (a) CLARIFICATION REGARDING APPLICATION OF
9 GUARANTEED RENEWABILITY OF INDIVIDUAL HEALTH
10 INSURANCE COVERAGE.—Section 2742 of the Public
11 Health Service Act (42 U.S.C. 300gg–42) is amended—
12 (1) in its heading, by inserting ''**AND CON-**
13 **TINUATION IN FORCE, INCLUDING PROHIBI-**
14 **TION OF RESCISSION,**'' after ''**GUARANTEED RE-**
15 **NEWABILITY**''; and
16 (2) in subsection (a), by inserting '', including
17 without rescission,'' after ''continue in force''.
18 (b) SECRETARIAL GUIDANCE REGARDING RESCIS-
19 SIONS.—Section 2742 of such Act (42 U.S.C. 300gg–42)
20 is amended by adding at the end the following:
21 ''(f) RESCISSION.—A health insurance issuer may re-
22 scind health insurance coverage only upon clear and con-
23 vincing evidence of fraud described in subsection (b)(2).
24 The Secretary, no later than July 1, 2010, shall issue

1 guidance implementing this requirement, including proce-
2 dures for independent, external third party review.''.
3 (c) OPPORTUNITY FOR INDEPENDENT, EXTERNAL
4 THIRD PARTY REVIEW IN CERTAIN CASES.—Subpart 1
5 of part B of title XXVII of such Act (42 U.S.C. 300gg–
6 41 et seq.) is amended by adding at the end the following:

7 **''SEC. 2746. OPPORTUNITY FOR INDEPENDENT, EXTERNAL**
8 **THIRD PARTY REVIEW IN CASES OF RESCIS-**
9 **SION.**

10 ''(a) NOTICE AND REVIEW RIGHT.—If a health in-
11 surance issuer determines to rescind health insurance cov-
12 erage for an individual in the individual market, before
13 such rescission may take effect the issuer shall provide the
14 individual with notice of such proposed rescission and an
15 opportunity for a review of such determination by an inde-
16 pendent, external third party under procedures specified
17 by the Secretary under section 2742(f).
18 ''(b) INDEPENDENT DETERMINATION.—If the indi-
19 vidual requests such review by an independent, external
20 third party of a rescission of health insurance coverage,
21 the coverage shall remain in effect until such third party
22 determines that the coverage may be rescinded under the
23 guidance issued by the Secretary under section 2742(f).''.
24 (d) EFFECTIVE DATE.—The amendments made by
25 this section shall apply on and after October 1, 2010, with

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

3 **SEC. 163. ADMINISTRATIVE SIMPLIFICATION.**

4 (a) STANDARDIZING ELECTRONIC ADMINISTRATIVE
5 TRANSACTIONS.—

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

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

12 "(a) STANDARDS FOR FINANCIAL AND ADMINISTRA-
13 TIVE TRANSACTIONS.—

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

17 "(2) GOALS FOR FINANCIAL AND ADMINISTRA-
18 TIVE TRANSACTIONS.—The goals for standards
19 under paragraph (1) are that such standards shall—

20 "(A) be unique with no conflicting or re-
21 dundant standards;

22 "(B) be authoritative, permitting no addi-
23 tions or constraints for electronic transactions,
24 including companion guides;

1 "(C) be comprehensive, efficient and ro-
2 bust, requiring minimal augmentation by paper
3 transactions or clarification by further commu-
4 nications;
5 "(D) enable the real-time (or near real-
6 time) determination of an individual's financial
7 responsibility at the point of service and, to the
8 extent possible, prior to service, including
9 whether the individual is eligible for a specific
10 service with a specific physician at a specific fa-
11 cility, which may include utilization of a ma-
12 chine-readable health plan beneficiary identi-
13 fication card;
14 "(E) enable, where feasible, near real-time
15 adjudication of claims;
16 "(F) provide for timely acknowledgment,
17 response, and status reporting applicable to any
18 electronic transaction deemed appropriate by
19 the Secretary;
20 "(G) describe all data elements (such as
21 reason and remark codes) in unambiguous
22 terms, not permit optional fields, require that
23 data elements be either required or conditioned
24 upon set values in other fields, and prohibit ad-
25 ditional conditions; and

1 "(H) harmonize all common data elements
2 across administrative and clinical transaction
3 standards.
4 "(3) TIME FOR ADOPTION.—Not later than 2
5 years after the date of implementation of the X12
6 Version 5010 transaction standards implemented
7 under this part, the Secretary shall adopt standards
8 under this section.
9 "(4) REQUIREMENTS FOR SPECIFIC STAND-
10 ARDS.—The standards under this section shall be
11 developed, adopted and enforced so as to—
12 "(A) clarify, refine, complete, and expand,
13 as needed, the standards required under section
14 1173;
15 "(B) require paper versions of standard-
16 ized transactions to comply with the same
17 standards as to data content such that a fully
18 compliant, equivalent electronic transaction can
19 be populated from the data from a paper
20 version;
21 "(C) enable electronic funds transfers, in
22 order to allow automated reconciliation with the
23 related health care payment and remittance ad-
24 vice;

1 "(D) require timely and transparent claim
2 and denial management processes, including
3 tracking, adjudication, and appeal processing ;
4 "(E) require the use of a standard elec-
5 tronic transaction with which health care pro-
6 viders may quickly and efficiently enroll with a
7 health plan to conduct the other electronic
8 transactions provided for in this part; and
9 "(F) provide for other requirements relat-
10 ing to administrative simplification as identified
11 by the Secretary, in consultation with stake-
12 holders.
13 "(5) BUILDING ON EXISTING STANDARDS.—In
14 developing the standards under this section, the Sec-
15 retary shall build upon existing and planned stand-
16 ards.
17 "(6) IMPLEMENTATION AND ENFORCEMENT.—
18 Not later than 6 months after the date of the enact-
19 ment of this section, the Secretary shall submit to
20 the appropriate committees of Congress a plan for
21 the implementation and enforcement, by not later
22 than 5 years after such date of enactment, of the
23 standards under this section. Such plan shall in-
24 clude—

1 “(A) a process and timeframe with mile-
2 stones for developing the complete set of stand-
3 ards;
4 “(B) an expedited upgrade program for
5 continually developing and approving additions
6 and modifications to the standards as often as
7 annually to improve their quality and extend
8 their functionality to meet evolving require-
9 ments in health care;
10 “(C) programs to provide incentives for,
11 and ease the burden of, implementation for cer-
12 tain health care providers, with special consid-
13 eration given to such providers serving rural or
14 underserved areas and ensure coordination with
15 standards, implementation specifications, and
16 certification criteria being adopted under the
17 HITECH Act;
18 “(D) programs to provide incentives for,
19 and ease the burden of, health care providers
20 who volunteer to participate in the process of
21 setting standards for electronic transactions;
22 “(E) an estimate of total funds needed to
23 ensure timely completion of the implementation
24 plan; and

1 "(F) an enforcement process that includes
2 timely investigation of complaints, random au-
3 dits to ensure compliance, civil monetary and
4 programmatic penalties for non-compliance con-
5 sistent with existing laws and regulations, and
6 a fair and reasonable appeals process building
7 off of enforcement provisions under this part.

8 "(b) LIMITATIONS ON USE OF DATA.—Nothing in
9 this section shall be construed to permit the use of infor-
10 mation collected under this section in a manner that would
11 adversely affect any individual.

12 "(c) PROTECTION OF DATA.—The Secretary shall en-
13 sure (through the promulgation of regulations or other-
14 wise) that all data collected pursuant to subsection (a)
15 are—

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

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

1 and from other inappropriate uses, as defined by the
2 Secretary.''.
3 (2) DEFINITIONS.—Section 1171 of such Act
4 (42 U.S.C. 1320d) is amended—
5 (A) in paragraph (7), by striking ''with
6 reference to'' and all that follows and inserting
7 ''with reference to a transaction or data ele-
8 ment of health information in section 1173
9 means implementation specifications, certifi-
10 cation criteria, operating rules, messaging for-
11 mats, codes, and code sets adopted or estab-
12 lished by the Secretary for the electronic ex-
13 change and use of information''; and
14 (B) by adding at the end the following new
15 paragraph:
16 ''(9) OPERATING RULES.—The term 'operating
17 rules' means business rules for using and processing
18 transactions. Operating rules should address the fol-
19 lowing:
20 ''(A) Requirements for data content using
21 available and established national standards.
22 ''(B) Infrastructure requirements that es-
23 tablish best practices for streamlining data flow
24 to yield timely execution of transactions.

1 "(C) Policies defining the transaction re-
2 lated rights and responsibilities for entities that
3 are transmitting or receiving data.".
4 (3) CONFORMING AMENDMENT.—Section
5 1179(a) of such Act (42 U.S.C. 1320d–8(a)) is
6 amended, in the matter before paragraph (1)—
7 (A) by inserting "on behalf of an indi-
8 vidual" after "1978)"; and
9 (B) by inserting "on behalf of an indi-
10 vidual" after "for a financial institution" and
11 (b) STANDARDS FOR CLAIMS ATTACHMENTS AND
12 COORDINATION OF BENEFITS .—
13 (1) STANDARD FOR HEALTH CLAIMS ATTACH-
14 MENTS.—Not later than 1 year after the date of the
15 enactment of this Act, the Secretary of Health and
16 Human Services shall promulgate a final rule to es-
17 tablish a standard for health claims attachment
18 transaction described in section 1173(a)(2)(B) of the
19 Social Security Act (42 U.S.C. 1320d-2(a)(2)(B))
20 and coordination of benefits.
21 (2) REVISION IN PROCESSING PAYMENT TRANS-
22 ACTIONS BY FINANCIAL INSTITUTIONS.—
23 (A) IN GENERAL.—Section 1179 of the So-
24 cial Security Act (42 U.S.C. 1320d–8) is
25 amended, in the matter before paragraph (1)—

1 (i) by striking "or is engaged" and in-
2 serting "and is engaged"; and
3 (ii) by inserting "(other than as a
4 business associate for a covered entity)"
5 after "for a financial institution".
6 (B) EFFECTIVE DATE.—The amendments
7 made by paragraph (1) shall apply to trans-
8 actions occurring on or after such date (not
9 later than 6 months after the date of the enact-
10 ment of this Act) as the Secretary of Health
11 and Human Services shall specify.

12 **SEC. 164. REINSURANCE PROGRAM FOR RETIREES.**

13 (a) ESTABLISHMENT.—
14 (1) IN GENERAL.—Not later than 90 days after
15 the date of the enactment of this Act, the Secretary
16 of Health and Human Services shall establish a tem-
17 porary reinsurance program (in this section referred
18 to as the "reinsurance program") to provide reim-
19 bursement to assist participating employment-based
20 plans with the cost of providing health benefits to
21 retirees and to eligible spouses, surviving spouses
22 and dependents of such retirees.
23 (2) DEFINITIONS.—For purposes of this sec-
24 tion:

1 (A) The term ''eligible employment-based
2 plan'' means a group health benefits plan
3 that—
4 (i) is maintained by one or more em-
5 ployers, former employers or employee as-
6 sociations, or a voluntary employees' bene-
7 ficiary association, or a committee or board
8 of individuals appointed to administer such
9 plan, and
10 (ii) provides health benefits to retir-
11 ees.
12 (B) The term ''health benefits'' means
13 medical, surgical, hospital, prescription drug,
14 and such other benefits as shall be determined
15 by the Secretary, whether self-funded or deliv-
16 ered through the purchase of insurance or oth-
17 erwise.
18 (C) The term ''participating employment-
19 based plan'' means an eligible employment-
20 based plan that is participating in the reinsur-
21 ance program.
22 (D) The term ''retiree'' means, with re-
23 spect to a participating employment-benefit
24 plan, an individual who—
25 (i) is 55 years of age or older;

1 (ii) is not eligible for coverage under
2 title XVIII of the Social Security Act; and
3 (iii) is not an active employee of an
4 employer maintaining the plan or of any
5 employer that makes or has made substan-
6 tial contributions to fund such plan.
7 (E) The term ''Secretary'' means Sec-
8 retary of Health and Human Services.
9 (b) PARTICIPATION.—To be eligible to participate in
10 the reinsurance program, an eligible employment-based
11 plan shall submit to the Secretary an application for par-
12 ticipation in the program, at such time, in such manner,
13 and containing such information as the Secretary shall re-
14 quire.
15 (c) PAYMENT.—
16 (1) SUBMISSION OF CLAIMS.—
17 (A) IN GENERAL.—Under the reinsurance
18 program, a participating employment-based
19 plan shall submit claims for reimbursement to
20 the Secretary which shall contain documenta-
21 tion of the actual costs of the items and serv-
22 ices for which each claim is being submitted.
23 (B) BASIS FOR CLAIMS.—Each claim sub-
24 mitted under subparagraph (A) shall be based
25 on the actual amount expended by the partici-

1 pating employment-based plan involved within
2 the plan year for the appropriate employment
3 based health benefits provided to a retiree or to
4 the spouse, surviving spouse, or dependent of a
5 retiree. In determining the amount of any claim
6 for purposes of this subsection, the partici-
7 pating employment-based plan shall take into
8 account any negotiated price concessions (such
9 as discounts, direct or indirect subsidies, re-
10 bates, and direct or indirect remunerations) ob-
11 tained by such plan with respect to such health
12 benefits. For purposes of calculating the
13 amount of any claim, the costs paid by the re-
14 tiree or by the spouse, surviving spouse, or de-
15 pendent of the retiree in the form of
16 deductibles, co-payments, and co-insurance shall
17 be included along with the amounts paid by the
18 participating employment-based plan.
19 (2) PROGRAM PAYMENTS AND LIMIT.—If the
20 Secretary determines that a participating employ-
21 ment-based plan has submitted a valid claim under
22 paragraph (1), the Secretary shall reimburse such
23 plan for 80 percent of that portion of the costs at-
24 tributable to such claim that exceeds $15,000, but is
25 less than $90,000. Such amounts shall be adjusted

1 each year based on the percentage increase in the
2 medical care component of the Consumer Price
3 Index (rounded to the nearest multiple of $1,000)
4 for the year involved.
5 (3) USE OF PAYMENTS.—Amounts paid to a
6 participating employment-based plan under this sub-
7 section shall be used to lower the costs borne di-
8 rectly by the participants and beneficiaries for health
9 benefits provided under such plan in the form of
10 premiums, co-payments, deductibles, co-insurance, or
11 other out-of-pocket costs. Such payments shall not
12 be used to reduce the costs of an employer maintain-
13 ing the participating employment-based plan. The
14 Secretary shall develop a mechanism to monitor the
15 appropriate use of such payments by such plans.
16 (4) APPEALS AND PROGRAM PROTECTIONS.—
17 The Secretary shall establish—
18 (A) an appeals process to permit partici-
19 pating employment-based plans to appeal a de-
20 termination of the Secretary with respect to
21 claims submitted under this section; and
22 (B) procedures to protect against fraud,
23 waste, and abuse under the program.
24 (5) AUDITS.—The Secretary shall conduct an-
25 nual audits of claims data submitted by partici-

1 pating employment-based plans under this section to
2 ensure that they are in compliance with the require-
3 ments of this section.
4 (d) RETIREE RESERVE TRUST FUND.—
5 (1) ESTABLISHMENT.—
6 (A) IN GENERAL.—There is established in
7 the Treasury of the United States a trust fund
8 to be known as the ''Retiree Reserve Trust
9 Fund'' (referred to in this section as the ''Trust
10 Fund''), that shall consist of such amounts as
11 may be appropriated or credited to the Trust
12 Fund as provided for in this subsection to en-
13 able the Secretary to carry out the reinsurance
14 program. Such amounts shall remain available
15 until expended.
16 (B) FUNDING.—There are hereby appro-
17 priated to the Trust Fund, out of any moneys
18 in the Treasury not otherwise appropriated, an
19 amount requested by the Secretary as necessary
20 to carry out this section, except that the total
21 of all such amounts requested shall not exceed
22 $10,000,000,000.
23 (C) APPROPRIATIONS FROM THE TRUST
24 FUND.—

1 (i) IN GENERAL.—Amounts in the
2 Trust Fund are appropriated to provide
3 funding to carry out the reinsurance pro-
4 gram and shall be used to carry out such
5 program.
6 (ii) BUDGETARY IMPLICATIONS.—
7 Amounts appropriated under clause (i),
8 and outlays flowing from such appropria-
9 tions, shall not be taken into account for
10 purposes of any budget enforcement proce-
11 dures including allocations under section
12 302(a) and (b) of the Balanced Budget
13 and Emergency Deficit Control Act and
14 budget resolutions for fiscal years during
15 which appropriations are made from the
16 Trust Fund.
17 (iii) LIMITATION TO AVAILABLE
18 FUNDS.—The Secretary has the authority
19 to stop taking applications for participa-
20 tion in the program or take such other
21 steps in reducing expenditures under the
22 reinsurance program in order to ensure
23 that expenditures under the reinsurance
24 program do not exceed the funds available
25 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;

1 (2) under section 205 facilitate outreach and
2 enrollment in such plans of Exchange-eligible indi-
3 viduals and employers described in section 202; and
4 (3) conduct such activities related to the Health
5 Insurance Exchange as required, including establish-
6 ment of a risk pooling mechanism under section 206
7 and consumer protections under subtitle D of title I.
8 (c) EXCHANGE-PARTICIPATING HEALTH BENEFITS
9 PLAN DEFINED.—In this division, the term ''Exchange-
10 participating health benefits plan'' means a qualified
11 health benefits plan that is offered through the Health In-
12 surance Exchange.

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

15 (a) ACCESS TO COVERAGE.—In accordance with this
16 section, all individuals are eligible to obtain coverage
17 through enrollment in an Exchange-participating health
18 benefits plan offered through the Health Insurance Ex-
19 change unless such individuals are enrolled in another
20 qualified health benefits plan or other acceptable coverage.
21 (b) DEFINITIONS.—In this division:
22 (1) EXCHANGE-ELIGIBLE INDIVIDUAL.—The
23 term ''Exchange-eligible individual'' means an indi-
24 vidual who is eligible under this section to be en-
25 rolled through the Health Insurance Exchange in an

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

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

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

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

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

21 (A) individuals described in subsection
22 (d)(1), including individuals described in para-
23 graphs (3) and (4) of subsection (d); and

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

1 (2) SECOND YEAR.—In Y2—
2 (A) individuals and employers described in
3 paragraph (1); and
4 (B) smaller employers described in sub-
5 section (e)(2).
6 (3) THIRD AND SUBSEQUENT YEARS.—In Y3
7 and subsequent years—
8 (A) individuals and employers described in
9 paragraph (2); and
10 (B) larger employers as permitted by the
11 Commissioner under subsection (e)(3).
12 (d) INDIVIDUALS.—
13 (1) INDIVIDUAL DESCRIBED.—Subject to the
14 succeeding provisions of this subsection, an indi-
15 vidual described in this paragraph is an individual
16 who—
17 (A) is not enrolled in coverage described in
18 subparagraphs (C) through (F) of paragraph
19 (2); and
20 (B) is not enrolled in coverage as a full-
21 time employee (or as a dependent of such an
22 employee) under a group health plan if the cov-
23 erage and an employer contribution under the
24 plan meet the requirements of section 312.

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

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

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

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

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

21 (D) MEDICAID.—Coverage for medical as-
22 sistance under title XIX of the Social Security
23 Act, excluding such coverage that is only avail-
24 able because of the application of subsection
25 (u), (z), or (aa) of section 1902 of such Act

1 (E) MEMBERS OF THE ARMED FORCES
2 AND DEPENDENTS (INCLUDING TRICARE).—
3 Coverage under chapter 55 of title 10, United
4 States Code, including similar coverage fur-
5 nished under section 1781 of title 38 of such
6 Code.
7 (F) VA.—Coverage under the veteran's
8 health care program under chapter 17 of title
9 38, United States Code, but only if the cov-
10 erage for the individual involved is determined
11 by the Commissioner in coordination with the
12 Secretary of Treasury to be not less than a level
13 specified by the Commissioner and Secretary of
14 Veteran's Affairs, in coordination with the Sec-
15 retary of Treasury, based on the individual's
16 priority for services as provided under section
17 1705(a) of such title.
18 (G) OTHER COVERAGE.—Such other health
19 benefits coverage, such as a State health bene-
20 fits risk pool, as the Commissioner, in coordina-
21 tion with the Secretary of the Treasury, recog-
22 nizes for purposes of this paragraph.
23 The Commissioner shall make determinations under
24 this paragraph in coordination with the Secretary of
25 the Treasury.

1 (3) TREATMENT OF CERTAIN NON-TRADI-
2 TIONAL MEDICAID ELIGIBLE INDIVIDUALS.—An indi-
3 vidual who is a non-traditional Medicaid eligible in-
4 dividual (as defined in section 205(e)(4)(C)) in a
5 State may be an Exchange-eligible individual if the
6 individual was enrolled in a qualified health benefits
7 plan, grandfathered health insurance coverage, or
8 current group health plan during the 6 months be-
9 fore the individual became a non-traditional Med-
10 icaid eligible individual. During the period in which
11 such an individual has chosen to enroll in an Ex-
12 change-participating health benefits plan, the indi-
13 vidual is not also eligible for medical assistance
14 under Medicaid.
15 (4) CONTINUING ELIGIBILITY PERMITTED.—
16 (A) IN GENERAL.—Except as provided in
17 subparagraph (B), once an individual qualifies
18 as an Exchange-eligible individual under this
19 subsection (including as an employee or depend-
20 ent of an employee of an Exchange-eligible em-
21 ployer) and enrolls under an Exchange-partici-
22 pating health benefits plan through the Health
23 Insurance Exchange, the individual shall con-
24 tinue to be treated as an Exchange-eligible indi-
25 vidual until the individual is no longer enrolled

1 with an Exchange-participating health benefits
2 plan.
3 (B) EXCEPTIONS.—
4 (i) IN GENERAL.—Subparagraph (A)
5 shall not apply to an individual once the
6 individual becomes eligible for coverage—
7 (I) under part A of the Medicare
8 program;
9 (II) under the Medicaid program
10 as a Medicaid eligible individual, ex-
11 cept as permitted under paragraph
12 (3) or clause (ii); or
13 (III) in such other circumstances
14 as the Commissioner may provide.
15 (ii) TRANSITION PERIOD.—In the case
16 described in clause (i)(II), the Commis-
17 sioner shall permit the individual to con-
18 tinue treatment under subparagraph (A)
19 until such limited time as the Commis-
20 sioner determines it is administratively fea-
21 sible, consistent with minimizing disruption
22 in the individual's access to health care.
23 (e) EMPLOYERS.—

1 (1) SMALLEST EMPLOYER.—Subject to para-
2 graph (4), smallest employers described in this para-
3 graph are employers with 10 or fewer employees.
4 (2) SMALLER EMPLOYERS.—Subject to para-
5 graph (4), smaller employers described in this para-
6 graph are employers that are not smallest employers
7 described in paragraph (1) and have 20 or fewer em-
8 ployees.
9 (3) LARGER EMPLOYERS.—
10 (A) IN GENERAL.—Beginning with Y3, the
11 Commissioner may permit employers not de-
12 scribed in paragraph (1) or (2) to be Exchange-
13 eligible employers.
14 (B) PHASE-IN.—In applying subparagraph
15 (A), the Commissioner may phase-in the appli-
16 cation of such subparagraph based on the num-
17 ber of full-time employees of an employer and
18 such other considerations as the Commissioner
19 deems appropriate.
20 (4) CONTINUING ELIGIBILITY.—Once an em-
21 ployer is permitted to be an Exchange-eligible em-
22 ployer under this subsection and enrolls employees
23 through the Health Insurance Exchange, the em-
24 ployer shall continue to be treated as an Exchange-
25 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.

1 (6) AFFILIATED GROUPS.—Any employer which
2 is part of a group of employers who are treated as
3 a single employer under subsection (b), (c), (m), or
4 (o) of section 414 of the Internal Revenue Code of
5 1986 shall be treated, for purposes of this subtitle,
6 as a single employer.
7 (7) OTHER COUNTING RULES.—The Commis-
8 sioner shall establish rules relating to how employees
9 are counted for purposes of carrying out this sub-
10 section.
11 (f) SPECIAL SITUATION AUTHORITY.—The Commis-
12 sioner shall have the authority to establish such rules as
13 may be necessary to deal with special situations with re-
14 gard to uninsured individuals and employers participating
15 as Exchange-eligible individuals and employers, such as
16 transition periods for individuals and employers who gain,
17 or lose, Exchange-eligible participation status, and to es-
18 tablish grace periods for premium payment.
19 (g) SURVEYS OF INDIVIDUALS AND EMPLOYERS.—
20 The Commissioner shall provide for periodic surveys of
21 Exchange-eligible individuals and employers concerning
22 satisfaction of such individuals and employers with the
23 Health Insurance Exchange and Exchange-participating
24 health benefits plans.
25 (h) EXCHANGE ACCESS STUDY.—

1 (1) IN GENERAL.—The Commissioner shall con-
2 duct a study of access to the Health Insurance Ex-
3 change for individuals and for employers, including
4 individuals and employers who are not eligible and
5 enrolled in Exchange-participating health benefits
6 plans. The goal of the study is to determine if there
7 are significant groups and types of individuals and
8 employers who are not Exchange eligible individuals
9 or employers, but who would have improved benefits
10 and affordability if made eligible for coverage in the
11 Exchange.
12 (2) ITEMS INCLUDED IN STUDY.—Such study
13 also shall examine—
14 (A) the terms, conditions, and affordability
15 of group health coverage offered by employers
16 and QHBP offering entities outside of the Ex-
17 change compared to Exchange-participating
18 health benefits plans; and
19 (B) the affordability-test standard for ac-
20 cess of certain employed individuals to coverage
21 in the Health Insurance Exchange.
22 (3) REPORT.—Not later than January 1 of Y3,
23 in Y6, and thereafter, the Commissioner shall sub-
24 mit to Congress on the study conducted under this
25 subsection and shall include in such report rec-

1 ommendations regarding changes in standards for
2 Exchange eligibility for for individuals and employ-
3 ers.

4 **SEC. 203. BENEFITS PACKAGE LEVELS.**

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

9 (b) LIMITATION ON HEALTH BENEFITS PLANS OF-
10 FERED BY OFFERING ENTITIES.—The Commissioner may
11 not enter into a contract with a QHBP offering entity
12 under section 204(c) for the offering of an Exchange-par-
13 ticipating health benefits plan in a service area unless the
14 following requirements are met:

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

18 (2) OPTIONAL OFFERING OF ENHANCED
19 PLAN.—If and only if the entity offers a basic plan
20 for such service area, the entity may offer one en-
21 hanced plan for such area.

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

1 (4) OPTIONAL OFFERING OF PREMIUM-PLUS
2 PLANS.—If and only if the entity offers a premium
3 plan for such service area, the entity may offer one
4 or more premium-plus plans for such area.
5 All such plans may be offered under a single contract with
6 the Commissioner.
7 (c) SPECIFICATION OF BENEFIT LEVELS FOR
8 PLANS.—
9 (1) IN GENERAL.—The Commissioner shall es-
10 tablish the following standards consistent with this
11 subsection and title I:
12 (A) BASIC, ENHANCED, AND PREMIUM
13 PLANS.—Standards for 3 levels of Exchange-
14 participating health benefits plans: basic, en-
15 hanced, and premium (in this division referred
16 to as a ''basic plan'', ''enhanced plan'', and
17 ''premium plan'', respectively).
18 (B) PREMIUM-PLUS PLAN BENEFITS.—
19 Standards for additional benefits that may be
20 offered, consistent with this subsection and sub-
21 title C of title I, under a premium plan (such
22 a plan with additional benefits referred to in
23 this division as a ''premium-plus plan'') .
24 (2) BASIC PLAN.—

1 (A) IN GENERAL.—A basic plan shall offer
2 the essential benefits package required under
3 title I for a qualified health benefits plan.
4 (B) TIERED COST-SHARING FOR AFFORD-
5 ABLE CREDIT ELIGIBLE INDIVIDUALS.—In the
6 case of an affordable credit eligible individual
7 (as defined in section 242(a)(1)) enrolled in an
8 Exchange-participating health benefits plan, the
9 benefits under a basic plan are modified to pro-
10 vide for the reduced cost-sharing for the income
11 tier applicable to the individual under section
12 244(c).
13 (3) ENHANCED PLAN.—A enhanced plan shall
14 offer, in addition to the level of benefits under the
15 basic plan, a lower level of cost-sharing as provided
16 under title I consistent with section 123(b)(5)(A).
17 (4) PREMIUM PLAN.—A premium plan shall
18 offer, in addition to the level of benefits under the
19 basic plan, a lower level of cost-sharing as provided
20 under title I consistent with section 123(b)(5)(B).
21 (5) PREMIUM-PLUS PLAN.—A premium-plus
22 plan is a premium plan that also provides additional
23 benefits, such as adult oral health and vision care,
24 approved by the Commissioner. The portion of the

1 premium that is attributable to such additional ben-
2 efits shall be separately specified.
3 (6) RANGE OF PERMISSIBLE VARIATION IN
4 COST-SHARING.—The Commissioner shall establish a
5 permissible range of variation of cost-sharing for
6 each basic, enhanced, and premium plan, except with
7 respect to any benefit for which there is no cost-
8 sharing permitted under the essential benefits pack-
9 age. Such variation shall permit a variation of not
10 more than plus (or minus) 10 percent in cost-shar-
11 ing with respect to each benefit category specified
12 under section 122.
13 (d) TREATMENT OF STATE BENEFIT MANDATES.—
14 Insofar as a State requires a health insurance issuer offer-
15 ing health insurance coverage to include benefits beyond
16 the essential benefits package, such requirement shall con-
17 tinue to apply to an Exchange-participating health bene-
18 fits plan, if the State has entered into an arrangement
19 satisfactory to the Commissioner to reimburse the Com-
20 missioner for the amount of any net increase in afford-
21 ability premium credits under subtitle C as a result of an
22 increase in premium in basic plans as a result of applica-
23 tion of such requirement.

1 **SEC. 204. CONTRACTS FOR THE OFFERING OF EXCHANGE-**
2 **PARTICIPATING HEALTH BENEFITS PLANS.**
3 (a) CONTRACTING DUTIES.—In carrying out section
4 201(b)(1) and consistent with this subtitle:
5 (1) OFFERING ENTITY AND PLAN STAND-
6 ARDS.—The Commissioner shall—
7 (A) establish standards necessary to imple-
8 ment the requirements of this title and title I
9 for—
10 (i) QHBP offering entities for the of-
11 fering of an Exchange-participating health
12 benefits plan; and
13 (ii) for Exchange-participating health
14 benefits plans; and
15 (B) certify QHBP offering entities and
16 qualified health benefits plans as meeting such
17 standards and requirements of this title and
18 title I for purposes of this subtitle.
19 (2) SOLICITING AND NEGOTIATING BIDS; CON-
20 TRACTS.—The Commissioner shall—
21 (A) solicit bids from QHBP offering enti-
22 ties for the offering of Exchange-participating
23 health benefits plans;
24 (B) based upon a review of such bids, ne-
25 gotiate with such entities for the offering of
26 such plans; and

1 (C) enter into contracts with such entities
2 for the offering of such plans through the
3 Health Insurance Exchange under terms (con-
4 sistent with this title) negotiated between the
5 Commissioner and such entities.
6 (3) FAR NOT APPLICABLE.—The provisions of
7 the Federal Acquisition Regulation shall not apply to
8 contracts between the Commissioner and QHBP of-
9 fering entities for the offering of Exchange-partici-
10 pating health benefits plans under this title.
11 (b) STANDARDS FOR QHBP OFFERING ENTITIES TO
12 OFFER EXCHANGE-PARTICIPATING HEALTH BENEFITS
13 PLANS.—The standards established under subsection
14 (a)(1)(A) shall require that, in order for a QHBP offering
15 entity to offer an Exchange-participating health benefits
16 plan, the entity must meet the following requirements:
17 (1) LICENSED.—The entity shall be licensed to
18 offer health insurance coverage under State law for
19 each State in which it is offering such coverage.
20 (2) DATA REPORTING.—The entity shall pro-
21 vide for the reporting of such information as the
22 Commissioner may specify, including information
23 necessary to administer the risk pooling mechanism
24 described in section 206(b) and information to ad-
25 dress disparities in health and health care.

1 (3) IMPLEMENTING AFFORDABILITY CRED-
2 ITS.—The entity shall provide for implementation of
3 the affordability credits provided for enrollees under
4 subtitle C, including the reduction in cost-sharing
5 under section 244(c).
6 (4) ENROLLMENT.—The entity shall accept all
7 enrollments under this subtitle, subject to such ex-
8 ceptions (such as capacity limitations) in accordance
9 with the requirements under title I for a qualified
10 health benefits plan. The entity shall notify the
11 Commissioner if the entity projects or anticipates
12 reaching such a capacity limitation that would result
13 in a limitation in enrollment.
14 (5) RISK POOLING PARTICIPATION.—The entity
15 shall participate in such risk pooling mechanism as
16 the Commissioner establishes under section 206(b).
17 (6) ESSENTIAL COMMUNITY PROVIDERS.—With
18 respect to the basic plan offered by the entity, the
19 entity shall contract for outpatient services with cov-
20 ered entities (as defined in section 340B(a)(4) of the
21 Public Health Service Act, as in effect as of July 1,
22 2009). The Commissioner shall specify the extent to
23 which and manner in which the previous sentence
24 shall apply in the case of a basic plan with respect
25 to which the Commissioner determines provides sub-

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

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

8 (8) ADDITIONAL REQUIREMENTS.—The entity
9 shall comply with other applicable requirements of
10 this title, as specified by the Commissioner, which
11 shall include standards regarding billing and collec-
12 tion practices for premiums and related grace peri-
13 ods and which may include standards to ensure that
14 the entity does not use coercive practices to force
15 providers not to contract with other entities offering
16 coverage through the Health Insurance Exchange.

17 (c) CONTRACTS.—

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

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

1 cally renewable from term to term in the absence of
2 notice of termination by either party.
3 (3) ENFORCEMENT OF NETWORK ADEQUACY.—
4 In the case of a health benefits plan of a QHBP of-
5 fering entity that uses a provider network, the con-
6 tract under this section with the entity shall provide
7 that if—
8 (A) the Commissioner determines that
9 such provider network does not meet such
10 standards as the Commissioner shall establish
11 under section 115; and
12 (B) an individual enrolled in such plan re-
13 ceives an item or service from a provider that
14 is not within such network;
15 then any cost-sharing for such item or service shall
16 be equal to the amount of such cost-sharing that
17 would be imposed if such item or service was fur-
18 nished by a provider within such network.
19 (4) OVERSIGHT AND ENFORCEMENT RESPON-
20 SIBILITIES.—The Commissioner shall establish proc-
21 esses, in coordination with State insurance regu-
22 lators, to oversee, monitor, and enforce applicable re-
23 quirements of this title with respect to QHBP offer-
24 ing entities offering Exchange-participating health
25 benefits plans and such plans, including the mar-

1 keting of such plans. Such processes shall include
2 the following:
3 (A) GRIEVANCE AND COMPLAINT MECHA-
4 NISMS.—The Commissioner shall establish, in
5 coordination with State insurance regulators, a
6 process under which Exchange-eligible individ-
7 uals and employers may file complaints con-
8 cerning violations of such standards.
9 (B) ENFORCEMENT.—In carrying out au-
10 thorities under this division relating to the
11 Health Insurance Exchange, the Commissioner
12 may impose one or more of the intermediate
13 sanctions described in section 142(c).
14 (C) TERMINATION.—
15 (i) IN GENERAL.—The Commissioner
16 may terminate a contract with a QHBP of-
17 fering entity under this section for the of-
18 fering of an Exchange-participating health
19 benefits plan if such entity fails to comply
20 with the applicable requirements of this
21 title. Any determination by the Commis-
22 sioner to terminate a contract shall be
23 made in accordance with formal investiga-
24 tion and compliance procedures established
25 by the Commissioner under which—

1 (I) the Commissioner provides
2 the entity with the reasonable oppor-
3 tunity to develop and implement a
4 corrective action plan to correct the
5 deficiencies that were the basis of the
6 Commissioner's determination; and
7 (II) the Commissioner provides
8 the entity with reasonable notice and
9 opportunity for hearing (including the
10 right to appeal an initial decision) be-
11 fore terminating the contract.
12 (ii) EXCEPTION FOR IMMINENT AND
13 SERIOUS RISK TO HEALTH.—Clause (i)
14 shall not apply if the Commissioner deter-
15 mines that a delay in termination, result-
16 ing from compliance with the procedures
17 specified in such clause prior to termi-
18 nation, would pose an imminent and seri-
19 ous risk to the health of individuals en-
20 rolled under the qualified health benefits
21 plan of the QHBP offering entity.
22 (D) CONSTRUCTION.—Nothing in this sub-
23 section shall be construed as preventing the ap-
24 plication of other sanctions under subtitle E of

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

3 **SEC. 205. OUTREACH AND ENROLLMENT OF EXCHANGE-EL-**
4 **IGIBLE INDIVIDUALS AND EMPLOYERS IN EX-**
5 **CHANGE-PARTICIPATING HEALTH BENEFITS**
6 **PLAN.**

7 (a) IN GENERAL.—
8 (1) OUTREACH.—The Commissioner shall con-
9 duct outreach activities consistent with subsection
10 (c), including through use of appropriate entities as
11 described in paragraph (4) of such subsection, to in-
12 form and educate individuals and employers about
13 the Health Insurance Exchange and Exchange-par-
14 ticipating health benefits plan options. Such out-
15 reach shall include outreach specific to vulnerable
16 populations, such as children, individuals with dis-
17 abilities, individuals with mental illness, and individ-
18 uals with other cognitive impairments.
19 (2) ELIGIBILITY.—The Commissioner shall
20 make timely determinations of whether individuals
21 and employers are Exchange-eligible individuals and
22 employers (as defined in section 202).
23 (3) ENROLLMENT.—The Commissioner shall es-
24 tablish and carry out an enrollment process for Ex-
25 change-eligible individuals and employers, including

1 at community locations, in accordance with sub-
2 section (b).
3 (b) ENROLLMENT PROCESS.—
4 (1) IN GENERAL.—The Commissioner shall es-
5 tablish a process consistent with this title for enroll-
6 ments in Exchange-participating health benefits
7 plans. Such process shall provide for enrollment
8 through means such as the mail, by telephone, elec-
9 tronically, and in person.
10 (2) ENROLLMENT PERIODS.—
11 (A) OPEN ENROLLMENT PERIOD.—The
12 Commissioner shall establish an annual open
13 enrollment period during which an Exchange-el-
14 igible individual or employer may elect to enroll
15 in an Exchange-participating health benefits
16 plan for the following plan year and an enroll-
17 ment period for affordability credits under sub-
18 title C. Such periods shall be during September
19 through November of each year, or such other
20 time that would maximize timeliness of income
21 verification for purposes of such subtitle. The
22 open enrollment period shall not be less than 30
23 days.
24 (B) SPECIAL ENROLLMENT.—The Com-
25 missioner shall also provide for special enroll-

1 ment periods to take into account special cir-
2 cumstances of individuals and employers, such
3 as an individual who—
4 (i) loses acceptable coverage;
5 (ii) experiences a change in marital or
6 other dependent status;
7 (iii) moves outside the service area of
8 the Exchange-participating health benefits
9 plan in which the individual is enrolled; or
10 (iv) experiences a significant change
11 in income.
12 (C) ENROLLMENT INFORMATION.—The
13 Commissioner shall provide for the broad dis-
14 semination of information to prospective enroll-
15 ees on the enrollment process, including before
16 each open enrollment period. In carrying out
17 the previous sentence, the Commissioner may
18 work with other appropriate entities to facilitate
19 such provision of information.
20 (3) AUTOMATIC ENROLLMENT FOR NON-MED-
21 ICAID ELIGIBLE INDIVIDUALS.—
22 (A) IN GENERAL.—The Commissioner
23 shall provide for a process under which individ-
24 uals who are Exchange-eligible individuals de-
25 scribed in subparagraph (B) are automatically

1 enrolled under an appropriate Exchange-partici-
2 pating health benefits plan. Such process may
3 involve a random assignment or some other
4 form of assignment that takes into account the
5 health care providers used by the individual in-
6 volved or such other relevant factors as the
7 Commissioner may specify.
8 (B) SUBSIDIZED INDIVIDUALS DE-
9 SCRIBED.—An individual described in this sub-
10 paragraph is an Exchange-eligible individual
11 who is either of the following:
12 (i) AFFORDABILITY CREDIT ELIGIBLE
13 INDIVIDUALS.—The individual—
14 (I) has applied for, and been de-
15 termined eligible for, affordability
16 credits under subtitle C;
17 (II) has not opted out from re-
18 ceiving such affordability credit; and
19 (III) does not otherwise enroll in
20 another Exchange-participating health
21 benefits plan.
22 (ii) INDIVIDUALS ENROLLED IN A
23 TERMINATED PLAN.—The individual is en-
24 rolled in an Exchange-participating health
25 benefits plan that is terminated (during or

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

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

10 (c) COVERAGE INFORMATION AND ASSISTANCE.—

11 (1) COVERAGE INFORMATION.—The Commis-
12 sioner shall provide for the broad dissemination of
13 information on Exchange-participating health bene-
14 fits plans offered under this title. Such information
15 shall be provided in a comparative manner, and shall
16 include information on benefits, premiums, cost-
17 sharing, quality, provider networks, and consumer
18 satisfaction.

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

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

1 tion on coverage under Exchange-participating
2 health benefits plans and file complaints;
3 (B) develop and disseminate information to
4 Exchange-eligible enrollees on their rights and
5 responsibilities;
6 (C) assist Exchange-eligible individuals in
7 selecting Exchange-participating health benefits
8 plans and obtaining benefits through such
9 plans; and
10 (D) ensure that the Internet website de-
11 scribed in subparagraph (A) and the informa-
12 tion described in subparagraph (B) is developed
13 using plain language (as defined in section
14 133(a)(2)).
15 (3) USE OF OTHER ENTITIES.—In carrying out
16 this subsection, the Commissioner may work with
17 other appropriate entities to facilitate the dissemina-
18 tion of information under this subsection and to pro-
19 vide assistance as described in paragraph (2).
20 (d) SPECIAL DUTIES RELATED TO MEDICAID AND
21 CHIP.—
22 (1) COVERAGE FOR CERTAIN NEWBORNS.—
23 (A) IN GENERAL.—In the case of a child
24 born in the United States who at the time of
25 birth is not otherwise covered under acceptable

1 coverage, for the period of time beginning on
2 the date of birth and ending on the date the
3 child otherwise is covered under acceptable cov-
4 erage (or, if earlier, the end of the month in
5 which the 60-day period, beginning on the date
6 of birth, ends), the child shall be deemed—
7 (i) to be a non-traditional Medicaid el-
8 igible individual (as defined in subsection
9 (e)(5)) for purposes of this division and
10 Medicaid; and
11 (ii) to have elected to enroll in Med-
12 icaid through the application of paragraph
13 (3).
14 (B) EXTENDED TREATMENT AS TRADI-
15 TIONAL MEDICAID ELIGIBLE INDIVIDUAL.—In
16 the case of a child described in subparagraph
17 (A) who at the end of the period referred to in
18 such subparagraph is not otherwise covered
19 under acceptable coverage, the child shall be
20 deemed (until such time as the child obtains
21 such coverage or the State otherwise makes a
22 determination of the child's eligibility for med-
23 ical assistance under its Medicaid plan pursuant
24 to section 1943(c)(1) of the Social Security
25 Act) to be a traditional Medicaid eligible indi-

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

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

12 (3) AUTOMATIC ENROLLMENT OF MEDICAID EL-
13 IGIBLE INDIVIDUALS INTO MEDICAID.—The Com-
14 missioner shall provide for a process under which an
15 individual who is described in section 202(d)(3) and
16 has not elected to enroll in an Exchange-partici-
17 pating health benefits plan is automatically enrolled
18 under Medicaid.

19 (4) NOTIFICATIONS.—The Commissioner shall
20 notify each State in Y1 and for purposes of section
21 1902(gg)(1) of the Social Security Act (as added by
22 section 1703(a)) whether the Health Insurance Ex-
23 change can support enrollment of children described
24 in paragraph (2) in such State in such year.

1 (e) MEDICAID COVERAGE FOR MEDICAID ELIGIBLE
2 INDIVIDUALS.—
3 (1) IN GENERAL.—
4 (A) CHOICE FOR LIMITED EXCHANGE-ELI-
5 GIBLE INDIVIDUALS.—As part of the enrollment
6 process under subsection (b), the Commissioner
7 shall provide the option, in the case of an Ex-
8 change-eligible individual described in section
9 202(d)(3), for the individual to elect to enroll
10 under Medicaid instead of under an Exchange-
11 participating health benefits plan. Such an indi-
12 vidual may change such election during an en-
13 rollment period under subsection (b)(2).
14 (B) MEDICAID ENROLLMENT OBLIGA-
15 TION.—An Exchange eligible individual may
16 apply, in the manner described in section
17 241(b)(1), for a determination of whether the
18 individual is a Medicaid-eligible individual. If
19 the individual is determined to be so eligible,
20 the Commissioner, through the Medicaid memo-
21 randum of understanding, shall provide for the
22 enrollment of the individual under the State
23 Medicaid plan in accordance with the Medicaid
24 memorandum of understanding under para-
25 graph (4). In the case of such an enrollment,

1 the State shall provide for the same periodic re-
2 determination of eligibility under Medicaid as
3 would otherwise apply if the individual had di-
4 rectly applied for medical assistance to the
5 State Medicaid agency.
6 (2) NON-TRADITIONAL MEDICAID ELIGIBLE IN-
7 DIVIDUALS.—In the case of a non-traditional Med-
8 icaid eligible individual described in section
9 202(d)(3) who elects to enroll under Medicaid under
10 paragraph (1)(A), the Commissioner shall provide
11 for the enrollment of the individual under the State
12 Medicaid plan in accordance with the Medicaid
13 memorandum of understanding under paragraph
14 (4).
15 (3) COORDINATED ENROLLMENT WITH STATE
16 THROUGH MEMORANDUM OF UNDERSTANDING.—
17 The Commissioner, in consultation with the Sec-
18 retary of Health and Human Services, shall enter
19 into a memorandum of understanding with each
20 State (each in this division referred to as a ''Med-
21 icaid memorandum of understanding'') with respect
22 to coordinating enrollment of individuals in Ex-
23 change-participating health benefits plans and under
24 the State's Medicaid program consistent with this
25 section and to otherwise coordinate the implementa-

1 tion of the provisions of this division with respect to
2 the Medicaid program. Such memorandum shall per-
3 mit the exchange of information consistent with the
4 limitations described in section 1902(a)(7) of the So-
5 cial Security Act. Nothing in this section shall be
6 construed as permitting such memorandum to mod-
7 ify or vitiate any requirement of a State Medicaid
8 plan.
9 (4) MEDICAID ELIGIBLE INDIVIDUALS.—For
10 purposes of this division:
11 (A) MEDICAID ELIGIBLE INDIVIDUAL.—
12 The term ''Medicaid eligible individual'' means
13 an individual who is eligible for medical assist-
14 ance under Medicaid.
15 (B) TRADITIONAL MEDICAID ELIGIBLE IN-
16 DIVIDUAL.—The term ''traditional Medicaid eli-
17 gible individual'' means a Medicaid eligible indi-
18 vidual other than an individual who is—
19 (i) a Medicaid eligible individual by
20 reason of the application of subclause
21 (VIII) of section 1902(a)(10)(A)(i) of the
22 Social Security Act; or
23 (ii) a childless adult not described in
24 section 1902(a)(10)(A) or (C) of such Act

1 (as in effect as of the day before the date
2 of the enactment of this Act).
3 (C) NON-TRADITIONAL MEDICAID ELIGI-
4 BLE INDIVIDUAL.—The term ''non-traditional
5 Medicaid eligible individual'' means a Medicaid
6 eligible individual who is not a traditional Med-
7 icaid eligible individual.
8 (f) EFFECTIVE CULTURALLY AND LINGUISTICALLY
9 APPROPRIATE COMMUNICATION.—In carrying out this
10 section, the Commissioner shall establish effective methods
11 for communicating in plain language and a culturally and
12 linguistically appropriate manner.
13 **SEC. 206. OTHER FUNCTIONS.**
14 (a) COORDINATION OF AFFORDABILITY CREDITS.—
15 The Commissioner shall coordinate the distribution of af-
16 fordability premium and cost-sharing credits under sub-
17 title C to QHBP offering entities offering Exchange-par-
18 ticipating health benefits plans.
19 (b) COORDINATION OF RISK POOLING.—The Com-
20 missioner shall establish a mechanism whereby there is an
21 adjustment made of the premium amounts payable among
22 QHBP offering entities offering Exchange-participating
23 health benefits plans of premiums collected for such plans
24 that takes into account (in a manner specified by the Com-
25 missioner) the differences in the risk characteristics of in-

1 dividuals and employers enrolled under the different Ex-
2 change-participating health benefits plans offered by such
3 entities so as to minimize the impact of adverse selection
4 of enrollees among the plans offered by such entities.

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

7 (1) ESTABLISHMENT; APPOINTMENT.—There is
8 hereby established the Office of the Special Inspec-
9 tor General for the Health Insurance Exchange, to
10 be headed by a Special Inspector General for the
11 Health Insurance Exchange (in this subsection re-
12 ferred to as the ''Special Inspector General'') to be
13 appointed by the President, by and with the advice
14 and consent of the Senate. The nomination of an in-
15 dividual as Special Inspector General shall be made
16 as soon as practicable after the establishment of the
17 program under this subtitle.

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

20 (A) conduct, supervise, and coordinate au-
21 dits, evaluations and investigations of the
22 Health Insurance Exchange to protect the in-
23 tegrity of the Health Insurance Exchange, as
24 well as the health and welfare of participants in
25 the Exchange;

1 (B) report both to the Commissioner and
2 to the Congress regarding program and man-
3 agement problems and recommendations to cor-
4 rect them;
5 (C) have other duties (described in para-
6 graphs (2) and (3) of section 121 of division A
7 of Public Law 110–343) in relation to the du-
8 ties described in the previous subparagraphs;
9 and
10 (D) have the authorities provided in sec-
11 tion 6 of the Inspector General Act of 1978 in
12 carrying out duties under this paragraph.
13 (3) APPLICATION OF OTHER SPECIAL INSPEC-
14 TOR GENERAL PROVISIONS.—The provisions of sub-
15 sections (b) (other than paragraphs (1) and (3)), (d)
16 (other than paragraph (1)), and (e) of section 121
17 of division A of the Emergency Economic Stabiliza-
18 tion Act of 2009 (Public Law 110–343) shall apply
19 to the Special Inspector General under this sub-
20 section in the same manner as such provisions apply
21 to the Special Inspector General under such section.
22 (4) REPORTS.—Not later than one year after
23 the confirmation of the Special Inspector General,
24 and annually thereafter, the Special Inspector Gen-
25 eral shall submit to the appropriate committees of

1 Congress a report summarizing the activities of the
2 Special Inspector General during the one year period
3 ending on the date such report is submitted.
4 (5) TERMINATION.—The Office of the Special
5 Inspector General shall terminate five years after
6 the date of the enactment of this Act.

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

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

16 (b) PAYMENTS FROM TRUST FUND.—The Commis-
17 sioner shall pay from time to time from the Trust Fund
18 such amounts as the Commissioner determines are nec-
19 essary to make payments to operate the Health Insurance
20 Exchange, including payments under subtitle C (relating
21 to affordability credits).

22 (c) TRANSFERS TO TRUST FUND.—
23 (1) DEDICATED PAYMENTS.—There is hereby
24 appropriated to the Trust Fund amounts equivalent
25 to the following:

1 (A) TAXES ON INDIVIDUALS NOT OBTAIN-
2 ING ACCEPTABLE COVERAGE.—The amounts re-
3 ceived in the Treasury under section 59B of the
4 Internal Revenue Code of 1986 (relating to re-
5 quirement of health insurance coverage for indi-
6 viduals).
7 (B) EMPLOYMENT TAXES ON EMPLOYERS
8 NOT PROVIDING ACCEPTABLE COVERAGE.—The
9 amounts received in the Treasury under section
10 3111(c) of the Internal Revenue Code of 1986
11 (relating to employers electing to not provide
12 health benefits).
13 (C) EXCISE TAX ON FAILURES TO MEET
14 CERTAIN HEALTH COVERAGE REQUIRE-
15 MENTS.—The amounts received in the Treasury
16 under section 4980H(b) (relating to excise tax
17 with respect to failure to meet health coverage
18 participation requirements).
19 (2) APPROPRIATIONS TO COVER GOVERNMENT
20 CONTRIBUTIONS.—There are hereby appropriated,
21 out of any moneys in the Treasury not otherwise ap-
22 propriated, to the Trust Fund, an amount equivalent
23 to the amount of payments made from the Trust
24 Fund under subsection (b) plus such amounts as are

1 necessary reduced by the amounts deposited under
2 paragraph (1).
3 (d) APPLICATION OF CERTAIN RULES.—Rules simi-
4 lar to the rules of subchapter B of chapter 98 of the Inter-
5 nal Revenue Code of 1986 shall apply with respect to the
6 Trust Fund.

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

9 (a) IN GENERAL.—If—
10 (1) a State (or group of States, subject to the
11 approval of the Commissioner) applies to the Com-
12 missioner for approval of a State-based Health In-
13 surance Exchange to operate in the State (or group
14 of States); and
15 (2) the Commissioner approves such State-
16 based Health Insurance Exchange,
17 then, subject to subsections (c) and (d), the State-based
18 Health Insurance Exchange shall operate, instead of the
19 Health Insurance Exchange, with respect to such State
20 (or group of States). The Commissioner shall approve a
21 State-based Health Insurance Exchange if it meets the re-
22 quirements for approval under subsection (b).
23 (b) REQUIREMENTS FOR APPROVAL.—The Commis-
24 sioner may not approve a State-based Health Insurance

1 Exchange under this section unless the following require-
2 ments are met:
3 (1) The State-based Health Insurance Ex-
4 change must demonstrate the capacity to and pro-
5 vide assurances satisfactory to the Commissioner
6 that the State-based Health Insurance Exchange will
7 carry out the functions specified for the Health In-
8 surance Exchange in the State (or States) involved,
9 including—
10 (A) negotiating and contracting with
11 QHBP offering entities for the offering of Ex-
12 change-participating health benefits plan, which
13 satisfy the standards and requirements of this
14 title and title I;
15 (B) enrolling Exchange-eligible individuals
16 and employers in such State in such plans;
17 (C) the establishment of sufficient local of-
18 fices to meet the needs of Exchange-eligible in-
19 dividuals and employers;
20 (D) administering affordability credits
21 under subtitle B using the same methodologies
22 (and at least the same income verification
23 methods) as would otherwise apply under such
24 subtitle and at a cost to the Federal Govern-

1 ment which does exceed the cost to the Federal
2 Government if this section did not apply; and
3 (E) enforcement activities consistent with
4 federal requirements.
5 (2) There is no more than one Health Insur-
6 ance Exchange operating with respect to any one
7 State.
8 (3) The State provides assurances satisfactory
9 to the Commissioner that approval of such an Ex-
10 change will not result in any net increase in expendi-
11 tures to the Federal Government.
12 (4) The State provides for reporting of such in-
13 formation as the Commissioner determines and as-
14 surances satisfactory to the Commissioner that it
15 will vigorously enforce violations of applicable re-
16 quirements.
17 (5) Such other requirements as the Commis-
18 sioner may specify.
19 (c) CEASING OPERATION.—
20 (1) IN GENERAL.—A State-based Health Insur-
21 ance Exchange may, at the option of each State in-
22 volved, and only after providing timely and reason-
23 able notice to the Commissioner, cease operation as
24 such an Exchange, in which case the Health Insur-
25 ance Exchange shall operate, instead of such State-

1 based Health Insurance Exchange, with respect to
2 such State (or States).
3 (2) TERMINATION; HEALTH INSURANCE EX-
4 CHANGE RESUMPTION OF FUNCTIONS.—The Com-
5 missioner may terminate the approval (for some or
6 all functions) of a State-based Health Insurance Ex-
7 change under this section if the Commissioner deter-
8 mines that such Exchange no longer meets the re-
9 quirements of subsection (b) or is no longer capable
10 of carrying out such functions in accordance with
11 the requirements of this subtitle. In lieu of termi-
12 nating such approval, the Commissioner may tempo-
13 rarily assume some or all functions of the State-
14 based Health Insurance Exchange until such time as
15 the Commissioner determines the State-based
16 Health Insurance Exchange meets such require-
17 ments of subsection (b) and is capable of carrying
18 out such functions in accordance with the require-
19 ments of this subtitle.
20 (3) EFFECTIVENESS.—The ceasing or termi-
21 nation of a State-based Health Insurance Exchange
22 under this subsection shall be effective in such time
23 and manner as the Commissioner shall specify.
24 (d) RETENTION OF AUTHORITY.—

1 (1) AUTHORITY RETAINED.—Enforcement au-
2 thorities of the Commissioner shall be retained by
3 the Commissioner.
4 (2) DISCRETION TO RETAIN ADDITIONAL AU-
5 THORITY.—The Commissioner may specify functions
6 of the Health Insurance Exchange that—
7 (A) may not be performed by a State-
8 based Health Insurance Exchange under this
9 section; or
10 (B) may be performed by the Commis-
11 sioner and by such a State-based Health Insur-
12 ance Exchange.
13 (e) REFERENCES.—In the case of a State-based
14 Health Insurance Exchange, except as the Commissioner
15 may otherwise specify under subsection (d), any references
16 in this subtitle to the Health Insurance Exchange or to
17 the Commissioner in the area in which the State-based
18 Health Insurance Exchange operates shall be deemed a
19 reference to the State-based Health Insurance Exchange
20 and the head of such Exchange, respectively.
21 (f) FUNDING.—In the case of a State-based Health
22 Insurance Exchange, there shall be assistance provided for
23 the operation of such Exchange in the form of a matching
24 grant with a State share of expenditures required.

1 **Subtitle B—Public Health**
2 **Insurance Option**

3 **SEC. 221. ESTABLISHMENT AND ADMINISTRATION OF A**
4 **PUBLIC HEALTH INSURANCE OPTION AS AN**
5 **EXCHANGE-QUALIFIED HEALTH BENEFITS**
6 **PLAN.**

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

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

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

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

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

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

7 (A) shall offer basic, enhanced, and pre-
8 mium plans; and

9 (B) may offer premium-plus plans.

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

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

1 health insurance option similar to the duties of the Medi-
2 care Beneficiary Ombudsman under section 1808(c)(2) of
3 the Social Security Act.
4 (e) DATA COLLECTION.—The Secretary shall collect
5 such data as may be required to establish premiums and
6 payment rates for the public health insurance option and
7 for other purposes under this subtitle, including to im-
8 prove quality and to reduce racial, ethnic, and other dis-
9 parities in health and health care.
10 (f) TREATMENT OF PUBLIC HEALTH INSURANCE OP-
11 TION.—With respect to the public health insurance option,
12 the Secretary shall be treated as a QHBP offering entity
13 offering an Exchange-participating health benefits plan.
14 (g) ACCESS TO FEDERAL COURTS.—The provisions
15 of Medicare (and related provisions of title II of the Social
16 Security Act) relating to access of Medicare beneficiaries
17 to Federal courts for the enforcement of rights under
18 Medicare, including with respect to amounts in con-
19 troversy, shall apply to the public health insurance option
20 and individuals enrolled under such option under this title
21 in the same manner as such provisions apply to Medicare
22 and Medicare beneficiaries.
23 **SEC. 222. PREMIUMS AND FINANCING.**
24 (a) ESTABLISHMENT OF PREMIUMS.—

1 (1) IN GENERAL.—The Secretary shall establish
2 geographically-adjusted premium rates for the public
3 health insurance option in a manner—
4 (A) that complies with the premium rules
5 established by the Commissioner under section
6 113 for Exchange-participating health benefit
7 plans; and
8 (B) at a level sufficient to fully finance the
9 costs of—
10 (i) health benefits provided by the
11 public health insurance option; and
12 (ii) administrative costs related to op-
13 erating the public health insurance option.
14 (2) CONTINGENCY MARGIN.—In establishing
15 premium rates under paragraph (1), the Secretary
16 shall include an appropriate amount for a contin-
17 gency margin.
18 (b) ACCOUNT.—
19 (1) ESTABLISHMENT.—There is established in
20 the Treasury of the United States an Account for
21 the receipts and disbursements attributable to the
22 operation of the public health insurance option, in-
23 cluding the start-up funding under paragraph (2).
24 Section 1854(g) of the Social Security Act shall
25 apply to receipts described in the previous sentence

1 in the same manner as such section applies to pay-
2 ments or premiums described in such section.
3 (2) START-UP FUNDING.—
4 (A) IN GENERAL.—In order to provide for
5 the establishment of the public health insurance
6 option there is hereby appropriated to the Sec-
7 retary, out of any funds in the Treasury not
8 otherwise appropriated, $2,000,000,000. In
9 order to provide for initial claims reserves be-
10 fore the collection of premiums, there is hereby
11 appropriated to the Secretary, out of any funds
12 in the Treasury not otherwise appropriated,
13 such sums as necessary to cover 90 days worth
14 of claims reserves based on projected enroll-
15 ment.
16 (B) AMORTIZATION OF START-UP FUND-
17 ING.—The Secretary shall provide for the re-
18 payment of the startup funding provided under
19 subparagraph (A) to the Treasury in an amor-
20 tized manner over the 10-year period beginning
21 with Y1.
22 (C) LIMITATION ON FUNDING.—Nothing in
23 this section shall be construed as authorizing
24 any additional appropriations to the Account,
25 other than such amounts as are otherwise pro-

1 vided with respect to other Exchange-partici-
2 pating health benefits plans.

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

4 (a) RATES ESTABLISHED BY SECRETARY.—
5 (1) IN GENERAL.—The Secretary shall establish
6 payment rates for the public health insurance option
7 for services and health care providers consistent with
8 this section and may change such payment rates in
9 accordance with section 224.
10 (2) INITIAL PAYMENT RULES.—
11 (A) IN GENERAL.—Except as provided in
12 subparagraph (B) and subsection (b)(1), during
13 Y1, Y2, and Y3, the Secretary shall base the
14 payment rates under this section for services
15 and providers described in paragraph (1) on the
16 payment rates for similar services and providers
17 under parts A and B of Medicare.
18 (B) EXCEPTIONS.—
19 (i) PRACTITIONERS' SERVICES.—Pay-
20 ment rates for practitioners' services other-
21 wise established under the fee schedule
22 under section 1848 of the Social Security
23 Act shall be applied without regard to the
24 provisions under subsection (f) of such sec-
25 tion 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).

1 (B) SERVICES DESCRIBED.—The services
2 described in this subparagraph are items and
3 professional services, under the public health in-
4 surance option by a physician or other health
5 care practitioner who participates in both Medi-
6 care and the public health insurance option.
7 (C) SPECIAL RULES.—A pediatrician and
8 any other health care practitioner who is a type
9 of practitioner that does not typically partici-
10 pate in Medicare (as determined by the Sec-
11 retary) shall also be eligible for the increased
12 payment rates under subparagraph (A).
13 (2) SUBSEQUENT PERIODS.— Beginning with
14 Y4 and for subsequent years, the Secretary shall
15 continue to use an administrative process to set such
16 rates in order to promote payment accuracy, to en-
17 sure adequate beneficiary access to providers, and to
18 promote affordablility and the efficient delivery of
19 medical care consistent with section 221(a). Such
20 rates shall not be set at levels expected to increase
21 overall medical costs under the option beyond what
22 would be expected if the process under subsection
23 (a)(2) and paragraph (1) of this subsection were
24 continued.

1 (3) ESTABLISHMENT OF A PROVIDER NET-
2 WORK.—Health care providers participating under
3 Medicare are participating providers in the public
4 health insurance option unless they opt out in a
5 process established by the Secretary.
6 (c) ADMINISTRATIVE PROCESS FOR SETTING
7 RATES.—Chapter 5 of title 5, United States Code shall
8 apply to the process for the initial establishment of pay-
9 ment rates under this section but not to the specific meth-
10 odology for establishing such rates or the calculation of
11 such rates.
12 (d) CONSTRUCTION.—Nothing in this subtitle shall
13 be construed as limiting the Secretary's authority to cor-
14 rect for payments that are excessive or deficient, taking
15 into account the provisions of section 221(a) and the
16 amounts paid for similar health care providers and serv-
17 ices under other Exchange-participating health benefits
18 plans.
19 (e) CONSTRUCTION.—Nothing in this subtitle shall be
20 construed as affecting the authority of the Secretary to
21 establish payment rates, including payments to provide for
22 the more efficient delivery of services, such as the initia-
23 tives provided for under section 224.
24 (f) LIMITATIONS ON REVIEW.—There shall be no ad-
25 ministrative or judicial review of a payment rate or meth-

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

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

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

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

19 (1) seeks to—
20 (A) improve health outcomes;
21 (B) reduce health disparities (including ra-
22 cial, ethnic, and other disparities);
23 (C) provide efficent and affordable care;
24 (D) address geographic variation in the
25 provision of health services; or

1 (E) prevent or manage chronic illness; and
2 (2) promotes care that is integrated, patient-
3 centered, quality, and efficient.
4 (c) ENCOURAGING THE USE OF HIGH VALUE SERV-
5 ICES.—To the extent allowed by the benefit standards ap-
6 plied to all Exchange-participating health benefits plans,
7 the public health insurance option may modify cost shar-
8 ing and payment rates to encourage the use of services
9 that promote health and value.
10 (d) NON-UNIFORMITY PERMITTED.—Nothing in this
11 subtitle shall prevent the Secretary from varying payments
12 based on different payment structure models (such as ac-
13 countable care organizations and medical homes) under
14 the public health insurance option for different geographic
15 areas.
16 **SEC. 225. PROVIDER PARTICIPATION.**
17 (a) IN GENERAL.—The Secretary shall establish con-
18 ditions of participation for health care providers under the
19 public health insurance option.
20 (b) LICENSURE OR CERTIFICATION.—The Secretary
21 shall not allow a health care provider to participate in the
22 public health insurance option unless such provider is ap-
23 propriately licensed or certified under State law.
24 (c) PAYMENT TERMS FOR PROVIDERS.—

1 (1) PHYSICIANS.—The Secretary shall provide
2 for the annual participation of physicians under the
3 public health insurance option, for which payment
4 may be made for services furnished during the year,
5 in one of 2 classes:
6 (A) PREFERRED PHYSICIANS.—Those phy-
7 sicians who agree to accept the payment rate
8 established under section 223 (without regard
9 to cost-sharing) as the payment in full.
10 (B) PARTICIPATING, NON-PREFERRED
11 PHYSICIANS.—Those physicians who agree not
12 to impose charges (in relation to the payment
13 rate described in section 223 for such physi-
14 cians) that exceed the ratio permitted under
15 section 1848(g)(2)(C) of the Social Security
16 Act.
17 (2) OTHER PROVIDERS.—The Secretary shall
18 provide for the participation (on an annual or other
19 basis specified by the Secretary) of health care pro-
20 viders (other than physicians) under the public
21 health insurance option under which payment shall
22 only be available if the provider agrees to accept the
23 payment rate established under section 223 (without
24 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 (1) the individual shall be eligible for, in accord-
2 ance with this subtitle, affordability credits con-
3 sisting of—
4 (A) an affordability premium credit under
5 section 243 to be applied against the premium
6 for the Exchange-participating health benefits
7 plan in which the individual is enrolled; and
8 (B) an affordability cost-sharing credit
9 under section 244 to be applied as a reduction
10 of the cost-sharing otherwise applicable to such
11 plan; and
12 (2) the Commissioner shall pay the QHBP of-
13 fering entity that offers such plan from the Health
14 Insurance Exchange Trust Fund the aggregate
15 amount of affordability credits for all affordable
16 credit eligible individuals enrolled in such plan.
17 (b) APPLICATION.—
18 (1) IN GENERAL.—An Exchange eligible indi-
19 vidual may apply to the Commissioner through the
20 Health Insurance Exchange or through another enti-
21 ty under an arrangement made with the Commis-
22 sioner, in a form and manner specified by the Com-
23 missioner. The Commissioner through the Health
24 Insurance Exchange or through another public enti-
25 ty under an arrangement made with the Commis-

1 sioner shall make a determination as to eligibility of
2 an individual for affordability credits under this sub-
3 title.The Commissioner shall establish a process
4 whereby, on the basis of information otherwise avail-
5 able, individuals may be deemed to be affordable
6 credit eligible individuals. In carrying this subtitle,
7 the Commissioner shall establish effective methods
8 that ensure that individuals with limited English
9 proficiency are able to apply for affordability credits.
10 (2) USE OF STATE MEDICAID AGENCIES.—If
11 the Commissioner determines that a State Medicaid
12 agency has the capacity to make a determination of
13 eligibility for affordability credits under this subtitle
14 and under the same standards as used by the Com-
15 missioner, under the Medicaid memorandum of un-
16 derstanding (as defined in section 205(c)(4))—
17 (A) the State Medicaid agency is author-
18 ized to conduct such determinations for any Ex-
19 change-eligible individual who requests such a
20 determination; and
21 (B) the Commissioner shall reimburse the
22 State Medicaid agency for the costs of con-
23 ducting such determinations.
24 (3) MEDICAID SCREEN AND ENROLL OBLIGA-
25 TION.—In the case of an application made under

1 paragraph (1), there shall be a determination of
2 whether the individual is a Medicaid-eligible indi-
3 vidual. If the individual is determined to be so eligi-
4 ble, the Commissioner, through the Medicaid memo-
5 randum of understanding, shall provide for the en-
6 rollment of the individual under the State Medicaid
7 plan in accordance with the Medicaid memorandum
8 of understanding. In the case of such an enrollment,
9 the State shall provide for the same periodic redeter-
10 mination of eligibility under Medicaid as would oth-
11 erwise apply if the individual had directly applied for
12 medical assistance to the State Medicaid agency.
13 (c) USE OF AFFORDABILITY CREDITS.—
14 (1) IN GENERAL.—In Y1 and Y2 an affordable
15 credit eligible individual may use an affordability
16 credit only with respect to a basic plan.
17 (2) FLEXIBILITY IN PLAN ENROLLMENT AU-
18 THORIZED.—Beginning with Y3, the Commissioner
19 shall establish a process to allow an affordability
20 credit to be used for enrollees in enhanced or pre-
21 mium plans. In the case of an affordable credit eligi-
22 ble individual who enrolls in an enhanced or pre-
23 mium plan, the individual shall be responsible for
24 any difference between the premium for such plan

1 and the affordable credit amount otherwise applica-
2 ble if the individual had enrolled in a basic plan.
3 (d) ACCESS TO DATA.—In carrying out this subtitle,
4 the Commissioner shall request from the Secretary of the
5 Treasury consistent with section 6103 of the Internal Rev-
6 enue Code of 1986 such information as may be required
7 to carry out this subtitle.
8 (e) NO CASH REBATES.—In no case shall an afford-
9 able credit eligible individual receive any cash payment as
10 a result of the application of this subtitle.
11 **SEC. 242. AFFORDABLE CREDIT ELIGIBLE INDIVIDUAL.**
12 (a) DEFINITION.—
13 (1) IN GENERAL.—For purposes of this divi-
14 sion, the term ''affordable credit eligible individual''
15 means, subject to subsection (b), an individual who
16 is lawfully present in a State in the United States
17 (other than as a nonimmigrant described in a sub-
18 paragraph (excluding subparagraphs (K), (T), (U),
19 and (V)) of section 101(a)(15) of the Immigration
20 and Nationality Act)—
21 (A) who is enrolled under an Exchange-
22 participating health benefits plan and is not en-
23 rolled under such plan as an employee (or de-
24 pendent of an employee) through an employer

1 qualified health benefits plan that meets the re-
2 quirements of section 312;
3 (B) with family income below 400 percent
4 of the Federal poverty level for a family of the
5 size involved; and
6 (C) who is not a Medicaid eligible indi-
7 vidual, other than an individual described in
8 section 202(d)(3) or an individual during a
9 transition period under section 202(d)(4)(B)(ii).
10 (2) TREATMENT OF FAMILY.—Except as the
11 Commissioner may otherwise provide, members of
12 the same family who are affordable credit eligible in-
13 dividuals shall be treated as a single affordable cred-
14 it individual eligible for the applicable credit for such
15 a family under this subtitle.
16 (b) LIMITATIONS ON EMPLOYEE AND DEPENDENT
17 DISQUALIFICATION.—
18 (1) IN GENERAL.—Subject to paragraph (2),
19 the term ''affordable credit eligible individual'' does
20 not include a full-time employee of an employer if
21 the employer offers the employee coverage (for the
22 employee and dependents) as a full-time employee
23 under a group health plan if the coverage and em-
24 ployer contribution under the plan meet the require-
25 ments of section 312.

1 (2) EXCEPTIONS.—
2 (A) FOR CERTAIN FAMILY CIR-
3 CUMSTANCES.—The Commissioner shall estab-
4 lish such exceptions and special rules in the
5 case described in paragraph (1) as may be ap-
6 propriate in the case of a divorced or separated
7 individual or such a dependent of an employee
8 who would otherwise be an affordable credit eli-
9 gible individual.
10 (B) FOR UNAFFORDABLE EMPLOYER COV-
11 ERAGE.—Beginning in Y2, in the case of full-
12 time employees for which the cost of the em-
13 ployee premium for coverage under a group
14 health plan would exceed 11 percent of current
15 family income (determined by the Commissioner
16 on the basis of verifiable documentation and
17 without regard to section 245), paragraph (1)
18 shall not apply.
19 (c) INCOME DEFINED.—
20 (1) IN GENERAL.—In this title, the term ''in-
21 come'' means modified adjusted gross income (as de-
22 fined in section 59B of the Internal Revenue Code
23 of 1986).
24 (2) STUDY OF INCOME DISREGARDS.—The
25 Commissioner shall conduct a study that examines

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

6 (d) CLARIFICATION OF TREATMENT OF AFFORD-
7 ABILITY CREDITS.—Affordabilty credits under this sub-
8 title shall not be treated, for purposes of title IV of the
9 Personal Responsibility and Work Opportunity Reconcili-
10 ation Act of 1996, to be a benefit provided under section
11 403 of such title.

12 **SEC. 243. AFFORDABLE PREMIUM CREDIT.**

13 (a) IN GENERAL.—The affordability premium credit
14 under this section for an affordable credit eligible indi-
15 vidual enrolled in an Exchange-participating health bene-
16 fits plan is in an amount equal to the amount (if any)
17 by which the premium for the plan (or, if less, the ref-
18 erence premium amount specified in subsection (c)), ex-
19 ceeds the affordable premium amount specified in sub-
20 section (b) for the individual.

21 (b) AFFORDABLE PREMIUM AMOUNT.—

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

1 (A) the premium percentage limit specified
2 in paragraph (2) for the individual based upon
3 the individual's family income for the plan year;
4 and
5 (B) the individual's family income for such
6 plan year.
7 (2) PREMIUM PERCENTAGE LIMITS BASED ON
8 TABLE.—The Commissioner shall establish premium
9 percentage limits so that for individuals whose fam-
10 ily income is within an income tier specified in the
11 table in subsection (d) such percentage limits shall
12 increase, on a sliding scale in a linear manner, from
13 the initial premium percentage to the final premium
14 percentage specified in such table for such income
15 tier.
16 (c) REFERENCE PREMIUM AMOUNT.—The reference
17 premium amount specified in this subsection for a plan
18 year for an individual in a premium rating area is equal
19 to the average premium for the 3 basic plans in the area
20 for the plan year with the lowest premium levels. In com-
21 puting such amount the Commissioner may exclude plans
22 with extremely limited enrollments.
23 (d) TABLE OF PREMIUM PERCENTAGE LIMITS AND
24 ACTUARIAL VALUE PERCENTAGES BASED ON INCOME
25 TIER.—

1 (1) IN GENERAL.—For purposes of this sub-
2 title, the table specified in this subsection is as fol-
3 lows:

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%

4 (2) SPECIAL RULES.—For purposes of applying
5 the table under paragraph (1)—
6 (A) FOR LOWEST LEVEL OF INCOME.—In
7 the case of an individual with income that does
8 not exceed 133 percent of FPL, the individual
9 shall be considered to have income that is 133%
10 of FPL.
11 (B) APPLICATION OF HIGHER ACTUARIAL
12 VALUE PERCENTAGE AT TIER TRANSITION
13 POINTS.—If two actuarial value percentages
14 may be determined with respect to an indi-
15 vidual, the actuarial value percentage shall be
16 the higher of such percentages.

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

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

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

5 (b) COST-SHARING REDUCTIONS.—The Commis-
6 sioner shall specify a reduction in cost-sharing amounts
7 and the annual limitation on cost-sharing specified in sec-
8 tion 122(c)(2)(B) under a basic plan for each income tier
9 specified in the table under section 243(d), with respect
10 to a year, in a manner so that, as estimated by the Com-
11 missioner, the actuarial value of the coverage with such
12 reduced cost-sharing amounts (and the reduced annual
13 cost-sharing limit) is equal to the actuarial value percent-
14 age (specified in the table under section 243(d) for the
15 income tier involved) of the full actuarial value if there
16 were no cost-sharing imposed under the plan.

17 (c) DETERMINATION AND PAYMENT OF COST-SHAR-
18 ING AFFORDABILITY CREDIT.—In the case of an afford-
19 able credit eligible individual in a tier enrolled in an Ex-
20 change-participating health benefits plan offered by a
21 QHBP offering entity, the Commissioner shall provide for
22 payment to the offering entity of an amount equivalent
23 to the increased actuarial value of the benefits under the
24 plan provided under section 203(c)(2)(B) resulting from
25 the reduction in cost-sharing described in subsection (b).

1 **SEC. 245. INCOME DETERMINATIONS.**

2 (a) IN GENERAL.—In applying this subtitle for an
3 affordability credit for an individual for a plan year, the
4 individual's income shall be the income (as defined in sec-
5 tion 242(c)) for the individual for the most recent taxable
6 year (as determined in accordance with rules of the Com-
7 missioner). The Federal poverty level applied shall be such
8 level in effect as of the date of the application.

9 (b) PROGRAM INTEGRITY; INCOME VERIFICATION
10 PROCEDURES.—

11 (1) PROGRAM INTEGRITY.—The Commissioner
12 shall take such steps as may be appropriate to en-
13 sure the accuracy of determinations and redeter-
14 minations under this subtitle.

15 (2) INCOME VERIFICATION.—

16 (A) IN GENERAL.—Upon an initial applica-
17 tion of an individual for an affordability credit
18 under this subtitle (or in applying section
19 242(b)) or upon an application for a change in
20 the affordability credit based upon a significant
21 change in family income described in subpara-
22 graph (A)—

23 (i) the Commissioner shall request
24 from the Secretary of the Treasury the dis-
25 closure to the Commissioner of such infor-
26 mation as may be permitted to verify the

1 information contained in such application;
2 and
3 (ii) the Commissioner shall use the in-
4 formation so disclosed to verify such infor-
5 mation.
6 (B) ALTERNATIVE PROCEDURES.—The
7 Commissioner shall establish procedures for the
8 verification of income for purposes of this sub-
9 title if no income tax return is available for the
10 most recent completed tax year.
11 (c) SPECIAL RULES.—
12 (1) CHANGES IN INCOME AS A PERCENT OF
13 FPL.—In the case that an individual's income (ex-
14 pressed as a percentage of the Federal poverty level
15 for a family of the size involved) for a plan year is
16 expected (in a manner specified by the Commis-
17 sioner) to be significantly different from the income
18 (as so expressed) used under subsection (a), the
19 Commissioner shall establish rules requiring an indi-
20 vidual to report, consistent with the mechanism es-
21 tablished under paragraph (2), significant changes
22 in such income (including a significant change in
23 family composition) to the Commissioner and requir-
24 ing the substitution of such income for the income
25 otherwise applicable.

1 (2) REPORTING OF SIGNIFICANT CHANGES IN
2 INCOME.—The Commissioner shall establish rules
3 under which an individual determined to be an af-
4 fordable credit eligible individual would be required
5 to inform the Commissioner when there is a signifi-
6 cant change in the family income of the individual
7 (expressed as a percentage of the FPL for a family
8 of the size involved) and of the information regard-
9 ing such change. Such mechanism shall provide for
10 guidelines that specify the circumstances that qual-
11 ify as a significant change, the verifiable information
12 required to document such a change, and the process
13 for submission of such information. If the Commis-
14 sioner receives new information from an individual
15 regarding the family income of the individual,the
16 Commissioner shall provide for a redetermination of
17 the individual's eligibility to be an affordable credit
18 eligible individual.
19 (3) TRANSITION FOR CHIP.—In the case of a
20 child described in section 202(d)(2), the Commis-
21 sioner shall establish rules under which the family
22 income of the child is deemed to be no greater than
23 the family income of the child as most recently de-
24 termined before Y1 by the State under title XXI of
25 the Social Security Act.

1 (4) STUDY OF GEOGRAPHIC VARIATION IN AP-
2 PLICATION OF FPL.—The Commissioner shall exam-
3 ine the feasibility and implication of adjusting the
4 application of the Federal poverty level under this
5 subtitle for different geographic areas so as to re-
6 flect the variations in cost-of-living among different
7 areas within the United States. If the Commissioner
8 determines that an adjustment is feasible, the study
9 should include a methodology to make such an ad-
10 justment. Not later than the first day of Y2, the
11 Commissioner shall submit to Congress a report on
12 such study and shall include such recommendations
13 as the Commissioner determines appropriate.
14 (d) PENALTIES FOR MISREPRESENTATION.—In the
15 case of an individual intentionally misrepresents family in-
16 come or the individual fails (without regard to intent) to
17 disclose to the Commissioner a significant change in fam-
18 ily income under subsection (c) in a manner that results
19 in the individual becoming an affordable credit eligible in-
20 dividual when the individual is not or in the amount of
21 the affordability credit exceeding the correct amount—
22 (1) the individual is liable for repayment of the
23 amount of the improper affordability credit; ;and
24 (2) in the case of such an intentional misrepre-
25 sentation or other egregious circumstances specified

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

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

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

9 (3) CONTRIBUTION IN LIEU OF COVERAGE.—
10 Beginning with Y2, if an employee declines such
11 offer but otherwise obtains coverage in an Exchange-
12 participating health benefits plan (other than by rea-
13 son of being covered by family coverage as a spouse
14 or dependent of the primary insured), the employer
15 shall make a timely contribution to the Health In-
16 surance Exchange with respect to each such em-
17 ployee in accordance with section 313.

18 **SEC. 312. EMPLOYER RESPONSIBILITY TO CONTRIBUTE TO-**
19 **WARDS EMPLOYEE AND DEPENDENT COV-**
20 **ERAGE.**

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

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

1 through an Exchange-participating health benefits
2 plan or other than through such a plan.
3 (2) EMPLOYER REQUIRED CONTRIBUTION.—
4 The employer timely pays to the issuer of such cov-
5 erage an amount not less than the employer required
6 contribution specified in subsection (b) for such cov-
7 erage.
8 (3) PROVISION OF INFORMATION.—The em-
9 ployer provides the Health Choices Commissioner,
10 the Secretary of Labor, the Secretary of Health and
11 Human Services, and the Secretary of the Treasury,
12 as applicable, with such information as the Commis-
13 sioner may require to ascertain compliance with the
14 requirements of this section.
15 (4) AUTOENROLLMENT OF EMPLOYEES.—The
16 employer provides for autoenrollment of the em-
17 ployee in accordance with subsection (c).
18 (b) REDUCTION OF EMPLOYEE PREMIUMS THROUGH
19 MINIMUM EMPLOYER CONTRIBUTION.—
20 (1) FULL-TIME EMPLOYEES.—The minimum
21 employer contribution described in this subsection
22 for coverage of a full-time employee (and, if any, the
23 employee's spouse and qualifying children (as de-
24 fined in section 152(c) of the Internal Revenue Code

1 of 1986) under a qualified health benefits plan (or
2 current employment-based health plan) is equal to—
3 (A) in case of individual coverage, not less
4 than 72.5 percent of the applicable premium
5 (as defined in section 4980B(f)(4) of such
6 Code, subject to paragraph (2)) of the lowest
7 cost plan offered by the employer that is a
8 qualified health benefits plan (or is such cur-
9 rent employment-based health plan); and
10 (B) in the case of family coverage which
11 includes coverage of such spouse and children,
12 not less 65 percent of such applicable premium
13 of such lowest cost plan.
14 (2) APPLICABLE PREMIUM FOR EXCHANGE COV-
15 ERAGE.—In this subtitle, the amount of the applica-
16 ble premium of the lowest cost plan with respect to
17 coverage of an employee under an Exchange-partici-
18 pating health benefits plan is the reference premium
19 amount under section 243(c) for individual coverage
20 (or, if elected, family coverage) for the premium rat-
21 ing area in which the individual or family resides.
22 (3) MINIMUM EMPLOYER CONTRIBUTION FOR
23 EMPLOYEES OTHER THAN FULL-TIME EMPLOY-
24 EES.—In the case of coverage for an employee who
25 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

1 plan for individual coverage under the plan option
2 with the lowest applicable employee premium.
3 (2) OPT-OUT.—In no case may an employer
4 automatically enroll an employee in a plan under
5 paragraph (1) if such employee makes an affirmative
6 election to opt out of such plan or to elect coverage
7 under an employment-based health benefits plan of-
8 fered by such employer. An employer shall provide
9 an employee with a 30-day period to make such an
10 affirmative election before the employer may auto-
11 matically enroll the employee in such a plan.
12 (3) NOTICE REQUIREMENTS.—
13 (A) IN GENERAL.—Each employer de-
14 scribed in paragraph (1) who automatically en-
15 rolls an employee into a plan as described in
16 such paragraph shall provide the employees,
17 within a reasonable period before the beginning
18 of each plan year (or, in the case of new em-
19 ployees, within a reasonable period before the
20 end of the enrollment period for such a new em-
21 ployee), written notice of the employees' rights
22 and obligations relating to the automatic enroll-
23 ment requirement under such paragraph. Such
24 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 (1) shall be paid to the Health Choices Com-
2 missioner for deposit into the Health Insurance Ex-
3 change Trust Fund, and
4 (2) shall not be applied against the premium of
5 the employee under the Exchange-participating
6 health benefits plan in which the employee is en-
7 rolled.
8 (b) SPECIAL RULES FOR SMALL EMPLOYERS.—
9 (1) IN GENERAL.—In the case of any employer
10 who is a small employer for any calendar year, sub-
11 section (a) shall be applied by substituting the appli-
12 cable percentage determined in accordance with the
13 following table for ''8 percent'':

If the annual payroll of such employer for the preceding calendar year:	The applicable percentage is:
Does not exceed $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

14 (2) SMALL EMPLOYER.—For purposes of this
15 subsection, the term ''small employer'' means any
16 employer for any calendar year if the annual payroll
17 of such employer for the preceding calendar year
18 does not exceed $400,000.
19 (3) ANNUAL PAYROLL.—For purposes of this
20 paragraph, the term ''annual payroll'' means, with
21 respect to any employer for any calendar year, the

1 aggregate wages paid by the employer during such
2 calendar year.
3 (4) AGGREGATION RULES.—Related employers
4 and predecessors shall be treated as a single em-
5 ployer for purposes of this subsection.

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

7 The Health Choices Commissioner (in coordination
8 with the Secretary of Labor, the Secretary of Health and
9 Human Services, and the Secretary of the Treasury) shall
10 have authority to set standards for determining whether
11 employers or insurers are undertaking any actions to af-
12 fect the risk pool within the Health Insurance Exchange
13 by inducing individuals to decline coverage under a quali-
14 fied health benefits plan (or current employment-based
15 health plan (within the meaning of section 102(b)) offered
16 by the employer and instead to enroll in an Exchange-par-
17 ticipating health benefits plan. An employer violating such
18 standards shall be treated as not meeting the require-
19 ments of this section.

1 **PART 2—SATISFACTION OF HEALTH COVERAGE**
2 **PARTICIPATION REQUIREMENTS**

3 **SEC. 321. SATISFACTION OF HEALTH COVERAGE PARTICI-**
4 **PATION REQUIREMENTS UNDER THE EM-**
5 **PLOYEE RETIREMENT INCOME SECURITY**
6 **ACT OF 1974.**

7 (a) IN GENERAL.—Subtitle B of title I of the Em-
8 ployee Retirement Income Security Act of 1974 is amend-
9 ed by adding at the end the following new part:

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

12 **"SEC. 801. ELECTION OF EMPLOYER TO BE SUBJECT TO NA-**
13 **TIONAL HEALTH COVERAGE PARTICIPATION**
14 **REQUIREMENTS.**

15 "(a) IN GENERAL.—An employer may make an elec-
16 tion with the Secretary to be subject to the health coverage
17 participation requirements.

18 "(b) TIME AND MANNER.—An election under sub-
19 section (a) may be made at such time and in such form
20 and manner as the Secretary may prescribe.

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

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

25 "(1) such election shall be treated as the estab-
26 lishment and maintenance of a group health plan (as

1 defined in section 733(a)) for purposes of this title,
2 subject to section 151 of the America's Affordable
3 Health Choices Act of 2009, and
4 ''(2) the health coverage participation require-
5 ments shall be deemed to be included as terms and
6 conditions of such plan.
7 ''(b) PERIODIC INVESTIGATIONS TO DISCOVER NON-
8 COMPLIANCE.—The Secretary shall regularly audit a rep-
9 resentative sampling of employers and group health plans
10 and conduct investigations and other activities under sec-
11 tion 504 with respect to such sampling of plans so as to
12 discover noncompliance with the health coverage participa-
13 tion requirements in connection with such plans. The Sec-
14 retary shall communicate findings of noncompliance made
15 by the Secretary under this subsection to the Secretary
16 of the Treasury and the Health Choices Commissioner.
17 The Secretary shall take such timely enforcement action
18 as appropriate to achieve compliance.
19 **''SEC. 803. HEALTH COVERAGE PARTICIPATION REQUIRE-**
20 **MENTS.**
21 ''For purposes of this part, the term 'health coverage
22 participation requirements' means the requirements of
23 part 1 of subtitle B of title III of division A of America's
24 Affordable Health Choices Act of 2009 (as in effect on
25 the date of the enactment of such Act).

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

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

9 "(b) SEPARATE ELECTIONS.—Under regulations pre-
10 scribed by the Secretary, separate elections may be made
11 under section 801 with respect to—

12 "(1) separate lines of business, and

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

15 **"SEC. 805. TERMINATION OF ELECTION IN CASES OF SUB-**
16 **STANTIAL NONCOMPLIANCE.**

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

24 **"SEC. 806. REGULATIONS.**

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

1 sions of this part, in accordance with section 324(a) of
2 the America's Affordable Health Choices Act of 2009. The
3 Secretary may promulgate any interim final rules as the
4 Secretary determines are appropriate to carry out this
5 part.''.
6 (b) ENFORCEMENT OF HEALTH COVERAGE PARTICI-
7 PATION REQUIREMENTS.—Section 502 of such Act (29
8 U.S.C. 1132) is amended—
9 (1) in subsection (a)(6), by striking ''para-
10 graph'' and all that follows through ''subsection (c)''
11 and inserting ''paragraph (2), (4), (5), (6), (7), (8),
12 (9), (10), or (11) of subsection (c)''; and
13 (2) in subsection (c), by redesignating the sec-
14 ond paragraph (10) as paragraph (12) and by in-
15 serting after the first paragraph (10) the following
16 new paragraph:
17 ''(11) HEALTH COVERAGE PARTICIPATION RE-
18 QUIREMENTS.—
19 ''(A) CIVIL PENALTIES.—In the case of
20 any employer who fails (during any period with
21 respect to which an election under section
22 801(a) is in effect) to satisfy the health cov-
23 erage participation requirements with respect to
24 any employee, the Secretary may assess a civil
25 penalty against the employer of $100 for each

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

4 "(B) HEALTH COVERAGE PARTICIPATION
5 REQUIREMENTS.—For purposes of this para-
6 graph, the term 'health coverage participation
7 requirements' has the meaning provided in sec-
8 tion 803.

9 "(C) LIMITATIONS ON AMOUNT OF PEN-
10 ALTY.—

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

21 "(ii) PENALTY NOT TO APPLY TO
22 FAILURES CORRECTED WITHIN 30 DAYS.—
23 No penalty shall be assessed under sub-
24 paragraph (A) with respect to any failure
25 if—

1 "(I) such failure was due to rea-
2 sonable cause and not to willful ne-
3 glect, and
4 "(II) such failure is corrected
5 during the 30-day period beginning on
6 the 1st date that the employer knew,
7 or exercising reasonable diligence
8 would have known, that such failure
9 existed.
10 "(iii) OVERALL LIMITATION FOR UN-
11 INTENTIONAL FAILURES.—In the case of
12 failures which are due to reasonable cause
13 and not to willful neglect, the penalty as-
14 sessed under subparagraph (A) for failures
15 during any 1-year period shall not exceed
16 the amount equal to the lesser of—
17 "(I) 10 percent of the aggregate
18 amount paid or incurred by the em-
19 ployer (or predecessor employer) dur-
20 ing the preceding 1-year period for
21 group health plans, or
22 "(II) $500,000.
23 "(D) ADVANCE NOTIFICATION OF FAILURE
24 PRIOR TO ASSESSMENT.—Before a reasonable
25 time prior to the assessment of any penalty

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

7 "(E) COORDINATION WITH EXCISE TAX.—
8 Under regulations prescribed in accordance
9 with section 324 of the America's Affordable
10 Health Choices Act of 2009, the Secretary and
11 the Secretary of the Treasury shall coordinate
12 the assessment of penalties under this section
13 in connection with failures to satisfy health cov-
14 erage participation requirements with the impo-
15 sition of excise taxes on such failures under sec-
16 tion 4980H(b) of the Internal Revenue Code of
17 1986 so as to avoid duplication of penalties
18 with respect to such failures.

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

23 (c) CLERICAL AMENDMENTS.—The table of contents
24 in section 1 of such Act is amended by inserting after the
25 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.".

1 (d) EFFECTIVE DATE.—The amendments made by
2 this section shall apply to periods beginning after Decem-
3 ber 31, 2012.

4 **SEC. 322. SATISFACTION OF HEALTH COVERAGE PARTICI-**
5 **PATION REQUIREMENTS UNDER THE INTER-**
6 **NAL REVENUE CODE OF 1986.**

7 (a) FAILURE TO ELECT, OR SUBSTANTIALLY COM-
8 PLY WITH, HEALTH COVERAGE PARTICIPATION RE-
9 QUIREMENTS.—For employment tax on employers who fail
10 to elect, or substantially comply with, the health coverage
11 participation requirements described in part 1, see section
12 3111(c) of the Internal Revenue Code of 1986 (as added
13 by section 412 of this Act).

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

1 **SEC. 323. SATISFACTION OF HEALTH COVERAGE PARTICI-**
2 **PATION REQUIREMENTS UNDER THE PUBLIC**
3 **HEALTH SERVICE ACT.**

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

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

9 "(a) ELECTION OF EMPLOYER TO BE SUBJECT TO
10 NATIONAL HEALTH COVERAGE PARTICIPATION REQUIRE-
11 MENTS.—

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

15 "(2) TIME AND MANNER.—An election under
16 paragraph (1) may be made at such time and in
17 such form and manner as the Secretary may pre-
18 scribe.

19 "(b) TREATMENT OF COVERAGE RESULTING FROM
20 ELECTION.—

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

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

1 section 151 of the America's Affordable Health
2 Choices Act of 2009, and
3 "(B) the health coverage participation re-
4 quirements shall be deemed to be included as
5 terms and conditions of such plan.
6 "(2) PERIODIC INVESTIGATIONS TO DETERMINE
7 COMPLIANCE WITH HEALTH COVERAGE PARTICIPA-
8 TION REQUIREMENTS.—The Secretary shall regu-
9 larly audit a representative sampling of employers
10 and conduct investigations and other activities with
11 respect to such sampling of employers so as to dis-
12 cover noncompliance with the health coverage par-
13 ticipation requirements in connection with such em-
14 ployers (during any period with respect to which an
15 election under subsection (a) is in effect). The Sec-
16 retary shall communicate findings of noncompliance
17 made by the Secretary under this subsection to the
18 Secretary of the Treasury and the Health Choices
19 Commissioner. The Secretary shall take such timely
20 enforcement action as appropriate to achieve compli-
21 ance.
22 "(c) HEALTH COVERAGE PARTICIPATION REQUIRE-
23 MENTS.—For purposes of this section, the term 'health
24 coverage participation requirements' means the require-
25 ments of part 1 of subtitle B of title III of division A

1 of the America's Affordable Health Choices Act of 2009
2 (as in effect on the date of the enactment of this section).
3 "(d) SEPARATE ELECTIONS.—Under regulations pre-
4 scribed by the Secretary, separate elections may be made
5 under subsection (a) with respect to full-time employees
6 and employees who are not full-time employees.
7 "(e) TERMINATION OF ELECTION IN CASES OF SUB-
8 STANTIAL NONCOMPLIANCE.—The Secretary may termi-
9 nate the election of any employer under subsection (a) if
10 the Secretary (in coordination with the Health Choices
11 Commissioner) determines that such employer is in sub-
12 stantial noncompliance with the health coverage participa-
13 tion requirements and shall refer any such determination
14 to the Secretary of the Treasury as appropriate.
15 "(f) ENFORCEMENT OF HEALTH COVERAGE PAR-
16 TICIPATION REQUIREMENTS.—
17 "(1) CIVIL PENALTIES.—In the case of any em-
18 ployer who fails (during any period with respect to
19 which the election under subsection (a) is in effect)
20 to satisfy the health coverage participation require-
21 ments with respect to any employee, the Secretary
22 may assess a civil penalty against the employer of
23 $100 for each day in the period beginning on the
24 date such failure first occurs and ending on the date
25 such failure is corrected.

1 "(2) LIMITATIONS ON AMOUNT OF PENALTY.—
2 "(A) PENALTY NOT TO APPLY WHERE
3 FAILURE NOT DISCOVERED EXERCISING REA-
4 SONABLE DILIGENCE.—No penalty shall be as-
5 sessed under paragraph (1) with respect to any
6 failure during any period for which it is estab-
7 lished to the satisfaction of the Secretary that
8 the employer did not know, or exercising rea-
9 sonable diligence would not have known, that
10 such failure existed.
11 "(B) PENALTY NOT TO APPLY TO FAIL-
12 URES CORRECTED WITHIN 30 DAYS.—No pen-
13 alty shall be assessed under paragraph (1) with
14 respect to any failure if—
15 "(i) such failure was due to reason-
16 able cause and not to willful neglect, and
17 "(ii) such failure is corrected during
18 the 30-day period beginning on the 1st
19 date that the employer knew, or exercising
20 reasonable diligence would have known,
21 that such failure existed.
22 "(C) OVERALL LIMITATION FOR UNINTEN-
23 TIONAL FAILURES.—In the case of failures
24 which are due to reasonable cause and not to
25 willful neglect, the penalty assessed under para-

1 graph (1) for failures during any 1-year period
2 shall not exceed the amount equal to the lesser
3 of—
4 "(i) 10 percent of the aggregate
5 amount paid or incurred by the employer
6 (or predecessor employer) during the pre-
7 ceding taxable year for group health plans,
8 or
9 "(ii) $500,000.
10 "(3) ADVANCE NOTIFICATION OF FAILURE
11 PRIOR TO ASSESSMENT.—Before a reasonable time
12 prior to the assessment of any penalty under para-
13 graph (1) with respect to any failure by an em-
14 ployer, the Secretary shall inform the employer in
15 writing of such failure and shall provide the em-
16 ployer information regarding efforts and procedures
17 which may be undertaken by the employer to correct
18 such failure.
19 "(4) ACTIONS TO ENFORCE ASSESSMENTS.—
20 The Secretary may bring a civil action in any Dis-
21 trict Court of the United States to collect any civil
22 penalty under this subsection.
23 "(5) COORDINATION WITH EXCISE TAX.—
24 Under regulations prescribed in accordance with sec-
25 tion 324 of the America's Affordable Health Choices

1 Act of 2009, the Secretary and the Secretary of the
2 Treasury shall coordinate the assessment of pen-
3 alties under paragraph (1) in connection with fail-
4 ures to satisfy health coverage participation require-
5 ments with the imposition of excise taxes on such
6 failures under section 4980H(b) of the Internal Rev-
7 enue Code of 1986 so as to avoid duplication of pen-
8 alties with respect to such failures.
9 ‘‘(6) DEPOSIT OF PENALTY COLLECTED.—Any
10 amount of penalty collected under this subsection
11 shall be deposited as miscellaneous receipts in the
12 Treasury of the United States.
13 ‘‘(g) REGULATIONS.—The Secretary may promulgate
14 such regulations as may be necessary or appropriate to
15 carry out the provisions of this section, in accordance with
16 section 324(a) of the America's Affordable Health Choices
17 Act of 2009. The Secretary may promulgate any interim
18 final rules as the Secretary determines are appropriate to
19 carry out this section.''.
20 (b) EFFECTIVE DATE.—The amendments made by
21 subsection (a) shall apply to periods beginning after De-
22 cember 31, 2012.

1 **SEC. 324. ADDITIONAL RULES RELATING TO HEALTH COV-**
2 **ERAGE PARTICIPATION REQUIREMENTS.**

3 (a) ASSURING COORDINATION.—The officers con-
4 sisting of the Secretary of Labor, the Secretary of the
5 Treasury, the Secretary of Health and Human Services,
6 and the Health Choices Commissioner shall ensure,
7 through the execution of an interagency memorandum of
8 understanding among such officers, that—

9 (1) regulations, rulings, and interpretations
10 issued by such officers relating to the same matter
11 over which two or more of such officers have respon-
12 sibility under subpart B of part 6 of subtitle B of
13 title I of the Employee Retirement Income Security
14 Act of 1974, section 4980H of the Internal Revenue
15 Code of 1986, and section 2793 of the Public Health
16 Service Act are administered so as to have the same
17 effect at all times; and

18 (2) coordination of policies relating to enforcing
19 the same requirements through such officers in
20 order to have a coordinated enforcement strategy
21 that avoids duplication of enforcement efforts and
22 assigns priorities in enforcement.

23 (b) MULTIEMPLOYER PLANS.—In the case of a group
24 health plan that is a multiemployer plan (as defined in
25 section 3(37) of the Employee Retirement Income Secu-
26 rity Act of 1974), the regulations prescribed in accordance

1 with subsection (a) by the officers referred to in subsection
2 (a) shall provide for the application of the health coverage
3 participation requirements to the plan sponsor and con-
4 tributing sponsors of such plan.

5 TITLE IV—AMENDMENTS TO IN-
6 TERNAL REVENUE CODE OF
7 1986

8 Subtitle A—Shared Responsibility

9 PART 1—INDIVIDUAL RESPONSIBILITY

10 SEC. 401. TAX ON INDIVIDUALS WITHOUT ACCEPTABLE
11 HEALTH CARE COVERAGE.

12 (a) IN GENERAL.—Subchapter A of chapter 1 of the
13 Internal Revenue Code of 1986 is amended by adding at
14 the end the following new part:

15 "PART VIII—HEALTH CARE RELATED TAXES

"SUBPART A. TAX ON INDIVIDUALS WITHOUT ACCEPTABLE HEALTH CARE COVERAGE.

16 "Subpart A—Tax on Individuals Without Acceptable
17 Health Care Coverage

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

18 "SEC. 59B. TAX ON INDIVIDUALS WITHOUT ACCEPTABLE
19 HEALTH CARE COVERAGE.

20 "(a) TAX IMPOSED.—In the case of any individual
21 who does not meet the requirements of subsection (d) at
22 any time during the taxable year, there is hereby imposed
23 a tax equal to 2.5 percent of the excess of—

1 "(1) the taxpayer's modified adjusted gross in-
2 come for the taxable year, over
3 "(2) the amount of gross income specified in
4 section 6012(a)(1) with respect to the taxpayer.
5 "(b) LIMITATIONS.—
6 "(1) TAX LIMITED TO AVERAGE PREMIUM.—
7 "(A) IN GENERAL.—The tax imposed
8 under subsection (a) with respect to any tax-
9 payer for any taxable year shall not exceed the
10 applicable national average premium for such
11 taxable year.
12 "(B) APPLICABLE NATIONAL AVERAGE
13 PREMIUM.—
14 "(i) IN GENERAL.—For purposes of
15 subparagraph (A), the 'applicable national
16 average premium' means, with respect to
17 any taxable year, the average premium (as
18 determined by the Secretary, in coordina-
19 tion with the Health Choices Commis-
20 sioner) for self-only coverage under a basic
21 plan which is offered in a Health Insur-
22 ance Exchange for the calendar year in
23 which such taxable year begins.
24 "(ii) FAILURE TO PROVIDE COVERAGE
25 FOR MORE THAN ONE INDIVIDUAL.—In the

1 case of any taxpayer who fails to meet the
2 requirements of subsection (e) with respect
3 to more than one individual during the tax-
4 able year, clause (i) shall be applied by
5 substituting 'family coverage' for 'self-only
6 coverage'.

7 ''(2) PRORATION FOR PART YEAR FAILURES.—
8 The tax imposed under subsection (a) with respect
9 to any taxpayer for any taxable year shall not exceed
10 the amount which bears the same ratio to the
11 amount of tax so imposed (determined without re-
12 gard to this paragraph and after application of para-
13 graph (1)) as—

14 ''(A) the aggregate periods during such
15 taxable year for which such individual failed to
16 meet the requirements of subsection (d), bears
17 to

18 ''(B) the entire taxable year.

19 ''(c) EXCEPTIONS.—

20 ''(1) DEPENDENTS.—Subsection (a) shall not
21 apply to any individual for any taxable year if a de-
22 duction is allowable under section 151 with respect
23 to such individual to another taxpayer for any tax-
24 able year beginning in the same calendar year as
25 such taxable year.

1 "(2) NONRESIDENT ALIENS.—Subsection (a)
2 shall not apply to any individual who is a non-
3 resident alien.
4 "(3) INDIVIDUALS RESIDING OUTSIDE UNITED
5 STATES.—Any qualified individual (as defined in
6 section 911(d)) (and any qualifying child residing
7 with such individual) shall be treated for purposes of
8 this section as covered by acceptable coverage during
9 the period described in subparagraph (A) or (B) of
10 section 911(d)(1), whichever is applicable.
11 "(4) INDIVIDUALS RESIDING IN POSSESSIONS
12 OF THE UNITED STATES.—Any individual who is a
13 bona fide resident of any possession of the United
14 States (as determined under section 937(a)) for any
15 taxable year (and any qualifying child residing with
16 such individual) shall be treated for purposes of this
17 section as covered by acceptable coverage during
18 such taxable year.
19 "(5) RELIGIOUS CONSCIENCE EXEMPTION.—
20 "(A) IN GENERAL.—Subsection (a) shall
21 not apply to any individual (and any qualifying
22 child residing with such individual) for any pe-
23 riod if such individual has in effect an exemp-
24 tion which certifies that such individual is a
25 member of a recognized religious sect or divi-

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

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

12 ‘‘(d) ACCEPTABLE COVERAGE REQUIREMENT.—

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

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

21 ‘‘(A) QUALIFIED HEALTH BENEFITS PLAN
22 COVERAGE.—Coverage under a qualified health
23 benefits plan (as defined in section 100(c) of
24 the America’s Affordable Health Choices Act of
25 2009).

1 "(B) GRANDFATHERED HEALTH INSUR-
2 ANCE COVERAGE; COVERAGE UNDER GRAND-
3 FATHERED EMPLOYMENT-BASED HEALTH
4 PLAN.—Coverage under a grandfathered health
5 insurance coverage (as defined in subsection (a)
6 of section 102 of the America's Affordable
7 Health Choices Act of 2009) or under a current
8 employment-based health plan (within the
9 meaning of subsection (b) of such section).
10 "(C) MEDICARE.—Coverage under part A
11 of title XVIII of the Social Security Act.
12 "(D) MEDICAID.—Coverage for medical as-
13 sistance under title XIX of the Social Security
14 Act.
15 "(E) MEMBERS OF THE ARMED FORCES
16 AND DEPENDENTS (INCLUDING TRICARE).—
17 Coverage under chapter 55 of title 10, United
18 States Code, including similar coverage fur-
19 nished under section 1781 of title 38 of such
20 Code.
21 "(F) VA.—Coverage under the veteran's
22 health care program under chapter 17 of title
23 38, United States Code, but only if the cov-
24 erage for the individual involved is determined
25 by the Secretary in coordination with the

1 Health Choices Commissioner to be not less
2 than the level specified by the Secretary of the
3 Treasury, in coordination with the Secretary of
4 Veteran's Affairs and the Health Choices Com-
5 missioner, based on the individual's priority for
6 services as provided under section 1705(a) of
7 such title.
8 "(G) OTHER COVERAGE.—Such other
9 health benefits coverage as the Secretary, in co-
10 ordination with the Health Choices Commis-
11 sioner, recognizes for purposes of this sub-
12 section.
13 "(e) OTHER DEFINITIONS AND SPECIAL RULES.—
14 "(1) QUALIFYING CHILD.—For purposes of this
15 section, the term 'qualifying child' has the meaning
16 given such term by section 152(c). With respect to
17 any period during which health coverage for a child
18 must be provided by an individual pursuant to a
19 child support order, such child shall be treated as a
20 qualifying child of such individual (and not as a
21 qualifying child of any other individual).
22 "(2) BASIC PLAN.—For purposes of this sec-
23 tion, the term 'basic plan' has the meaning given
24 such term under section 100(c) of the America's Af-
25 fordable Health Choices Act of 2009.

1 “(3) HEALTH INSURANCE EXCHANGE.—For
2 purposes of this section, the term ‘Health Insurance
3 Exchange’ has the meaning given such term under
4 section 100(c) of the America’s Affordable Health
5 Choices Act of 2009, including any State-based
6 health insurance exchange approved for operation
7 under section 208 of such Act.

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

11 “(5) MODIFIED ADJUSTED GROSS INCOME.—
12 For purposes of this section, the term ‘modified ad-
13 justed gross income’ means adjusted gross income—

14 “(A) determined without regard to section
15 911, and

16 “(B) increased by the amount of interest
17 received or accrued by the taxpayer during the
18 taxable year which is exempt from tax.

19 “(6) NOT TREATED AS TAX IMPOSED BY THIS
20 CHAPTER FOR CERTAIN PURPOSES.—The tax im-
21 posed under this section shall not be treated as tax
22 imposed by this chapter for purposes of determining
23 the amount of any credit under this chapter or for
24 purposes of section 55.

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

7 ''(1) exemption from the tax imposed under
8 subsection (a) in cases of de minimis lapses of ac-
9 ceptable coverage, and

10 ''(2) a process for applying for a waiver of the
11 application of subsection (a) in cases of hardship.''.

12 (b) INFORMATION REPORTING.—

13 (1) IN GENERAL.—Subpart B of part III of
14 subchapter A of chapter 61 of such Code is amended
15 by inserting after section 6050W the following new
16 section:

17 **''SEC. 6050X. RETURNS RELATING TO HEALTH INSURANCE**
18 **COVERAGE.**

19 ''(a) REQUIREMENT OF REPORTING.—Every person
20 who provides acceptable coverage (as defined in section
21 59B(d)) to any individual during any calendar year shall,
22 at such time as the Secretary may prescribe, make the
23 return described in subsection (b) with respect to such in-
24 dividual.

1 "(b) FORM AND MANNER OF RETURNS.—A return
2 is described in this subsection if such return—
3 "(1) is in such form as the Secretary may pre-
4 scribe, and
5 "(2) contains—
6 "(A) the name, address, and TIN of the
7 primary insured and the name of each other in-
8 dividual obtaining coverage under the policy,
9 "(B) the period for which each such indi-
10 vidual was provided with the coverage referred
11 to in subsection (a), and
12 "(C) such other information as the Sec-
13 retary may require.
14 "(c) STATEMENTS TO BE FURNISHED TO INDIVID-
15 UALS WITH RESPECT TO WHOM INFORMATION IS RE-
16 QUIRED.—Every person required to make a return under
17 subsection (a) shall furnish to each primary insured whose
18 name is required to be set forth in such return a written
19 statement showing—
20 "(1) the name and address of the person re-
21 quired to make such return and the phone number
22 of the information contact for such person, and
23 "(2) the information required to be shown on
24 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 governmental 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

1 (FF) and inserting ", or", and by inserting
2 after subparagraph (FF) the following new sub-
3 paragraph:
4 "(GG) section 6050X (relating to returns
5 relating to health insurance coverage).".
6 (c) RETURN REQUIREMENT.—Subsection (a) of sec-
7 tion 6012 of such Code is amended by inserting after
8 paragraph (9) the following new paragraph:
9 "(10) Every individual to whom section 59B(a)
10 applies and who fails to meet the requirements of
11 section 59B(d) with respect to such individual or
12 any qualifying child (as defined in section 152(c)) of
13 such individual.".
14 (d) CLERICAL AMENDMENTS.—
15 (1) The table of parts for subchapter A of chap-
16 ter 1 of the Internal Revenue Code of 1986 is
17 amended by adding at the end the following new
18 item:

"PART VIII. HEALTH CARE RELATED TAXES.".

19 (2) The table of sections for subpart B of part
20 III of subchapter A of chapter 61 is amended by
21 adding at the end the following new item:

"Sec. 6050X. Returns relating to health insurance coverage.".

22 (e) SECTION 15 NOT TO APPLY.—The amendment
23 made by subsection (a) shall not be treated as a change

1 in a rate of tax for purposes of section 15 of the Internal
2 Revenue Code of 1986.
3 (f) EFFECTIVE DATE.—
4 (1) IN GENERAL.—The amendments made by
5 this section shall apply to taxable years beginning
6 after December 31, 2012.
7 (2) RETURNS.—The amendments made by sub-
8 section (b) shall apply to calendar years beginning
9 after December 31, 2012.

10 **PART 2—EMPLOYER RESPONSIBILITY**

11 **SEC. 411. ELECTION TO SATISFY HEALTH COVERAGE PAR-**
12 **TICIPATION REQUIREMENTS.**

13 (a) IN GENERAL.—Chapter 43 of the Internal Rev-
14 enue Code of 1986 is amended by adding at the end the
15 following new section:

16 **"SEC. 4980H. ELECTION WITH RESPECT TO HEALTH COV-**
17 **ERAGE PARTICIPATION REQUIREMENTS.**

18 "(a) ELECTION OF EMPLOYER RESPONSIBILITY TO
19 PROVIDE HEALTH COVERAGE.—
20 "(1) IN GENERAL.—Subsection (b) shall apply
21 to any employer with respect to whom an election
22 under paragraph (2) is in effect.
23 "(2) TIME AND MANNER.—An employer may
24 make an election under this paragraph at such time

1 and in such form and manner as the Secretary may
2 prescribe.
3 “(3) AFFILIATED GROUPS.—In the case of any
4 employer which is part of a group of employers who
5 are treated as a single employer under subsection
6 (b), (c), (m), or (o) of section 414, the election
7 under paragraph (2) shall be made by such person
8 as the Secretary may provide. Any such election,
9 once made, shall apply to all members of such
10 group.
11 “(4) SEPARATE ELECTIONS.—Under regula-
12 tions prescribed by the Secretary, separate elections
13 may be made under paragraph (2) with respect to—
14 “(A) separate lines of business, and
15 “(B) full-time employees and employees
16 who are not full-time employees.
17 “(5) TERMINATION OF ELECTION IN CASES OF
18 SUBSTANTIAL NONCOMPLIANCE.—The Secretary
19 may terminate the election of any employer under
20 paragraph (2) if the Secretary (in coordination with
21 the Health Choices Commissioner) determines that
22 such employer is in substantial noncompliance with
23 the health coverage participation requirements.

1 "(b) EXCISE TAX WITH RESPECT TO FAILURE TO
2 MEET HEALTH COVERAGE PARTICIPATION REQUIRE-
3 MENTS.—
4 "(1) IN GENERAL.—In the case of any employer
5 who fails (during any period with respect to which
6 the election under subsection (a) is in effect) to sat-
7 isfy the health coverage participation requirements
8 with respect to any employee to whom such election
9 applies, there is hereby imposed on each such failure
10 with respect to each such employee a tax of $100 for
11 each day in the period beginning on the date such
12 failure first occurs and ending on the date such fail-
13 ure is corrected.
14 "(2) LIMITATIONS ON AMOUNT OF TAX.—
15 "(A) TAX NOT TO APPLY WHERE FAILURE
16 NOT DISCOVERED EXERCISING REASONABLE
17 DILIGENCE.—No tax shall be imposed by para-
18 graph (1) on any failure during any period for
19 which it is established to the satisfaction of the
20 Secretary that the employer neither knew, nor
21 exercising reasonable diligence would have
22 known, that such failure existed.
23 "(B) TAX NOT TO APPLY TO FAILURES
24 CORRECTED WITHIN 30 DAYS.—No tax shall be
25 imposed by paragraph (1) on any failure if—

1 "(i) such failure was due to reason-
2 able cause and not to willful neglect, and
3 "(ii) such failure is corrected during
4 the 30-day period beginning on the 1st
5 date that the employer knew, or exercising
6 reasonable diligence would have known,
7 that such failure existed.
8 "(C) OVERALL LIMITATION FOR UNINTEN-
9 TIONAL FAILURES.—In the case of failures
10 which are due to reasonable cause and not to
11 willful neglect, the tax imposed by subsection
12 (a) for failures during the taxable year of the
13 employer shall not exceed the amount equal to
14 the lesser of—
15 "(i) 10 percent of the aggregate
16 amount paid or incurred by the employer
17 (or predecessor employer) during the pre-
18 ceding taxable year for employment-based
19 health plans, or
20 "(ii) $500,000.
21 "(D) COORDINATION WITH OTHER EN-
22 FORCEMENT PROVISIONS.—The tax imposed
23 under paragraph (1) with respect to any failure
24 shall be reduced (but not below zero) by the
25 amount of any civil penalty collected under sec-

1 tion 502(c)(11) of the Employee Retirement In-
2 come Security Act of 1974 or section 2793(g)
3 of the Public Health Service Act with respect to
4 such failure.

5 ''(c) HEALTH COVERAGE PARTICIPATION REQUIRE-
6 MENTS.—For purposes of this section, the term 'health
7 coverage participation requirements' means the require-
8 ments of part I of subtitle B of title III of the America's
9 Affordable Health Choices Act of 2009 (as in effect on
10 the date of the enactment of this section).''.

11 (b) CLERICAL AMENDMENT.—The table of sections
12 for chapter 43 of such Code is amended by adding at the
13 end the following new item:

''Sec. 4980H. Election to satisfy health coverage participation requirements.''.

14 (c) EFFECTIVE DATE.—The amendments made by
15 this section shall apply to periods beginning after Decem-
16 ber 31, 2012.

17 **SEC. 412. RESPONSIBILITIES OF NONELECTING EMPLOY-**
18 **ERS.**

19 (a) IN GENERAL.—Section 3111 of the Internal Rev-
20 enue Code of 1986 is amended by redesignating subsection
21 (c) as subsection (d) and by inserting after subsection (b)
22 the following new subsection:

23 ''(c) EMPLOYERS ELECTING TO NOT PROVIDE
24 HEALTH BENEFITS.—

1 "(1) IN GENERAL.—In addition to other taxes,
2 there is hereby imposed on every nonelecting em-
3 ployer an excise tax, with respect to having individ-
4 uals in his employ, equal to 8 percent of the wages
5 (as defined in section 3121(a)) paid by him with re-
6 spect to employment (as defined in section 3121(b)).
7 "(2) SPECIAL RULES FOR SMALL EMPLOY-
8 ERS.—
9 "(A) IN GENERAL.—In the case of any em-
10 ployer who is small employer for any calendar
11 year, paragraph (1) shall be applied by sub-
12 stituting the applicable percentage determined
13 in accordance with the following table for '8
14 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

15 "(B) SMALL EMPLOYER.—For purposes of
16 this paragraph, the term 'small employer'
17 means any employer for any calendar year if
18 the annual payroll of such employer for the pre-
19 ceding calendar year does not exceed $400,000.
20 "(C) ANNUAL PAYROLL.—For purposes of
21 this paragraph, the term 'annual payroll'
22 means, with respect to any employer for any

1 calendar year, the aggregate wages (as defined
2 in section 3121(a)) paid by him with respect to
3 employment (as defined in section 3121(b))
4 during such calendar year.

5 ''(3) NONELECTING EMPLOYER.—For purposes
6 of paragraph (1), the term 'nonelecting employer'
7 means any employer for any period with respect to
8 which such employer does not have an election under
9 section 4980H(a) in effect.

10 ''(4) SPECIAL RULE FOR SEPARATE ELEC-
11 TIONS.—In the case of an employer who makes a
12 separate election described in section 4980H(a)(4)
13 for any period, paragraph (1) shall be applied for
14 such period by taking into account only the wages
15 paid to employees who are not subject to such elec-
16 tion.

17 ''(5) AGGREGATION; PREDECESSORS.—For pur-
18 poses of this subsection—

19 ''(A) all persons treated as a single em-
20 ployer under subsection (b), (c), (m), or (o) of
21 section 414 shall be treated as 1 employer, and

22 ''(B) any reference to any person shall be
23 treated as including a reference to any prede-
24 cessor of such person.''.

1 (b) DEFINITIONS.—Section 3121 of such Code is
2 amended by adding at the end the following new sub-
3 section:
4 "(aa) SPECIAL RULES FOR TAX ON EMPLOYERS
5 ELECTING NOT TO PROVIDE HEALTH BENEFITS.—For
6 purposes of section 3111(c)—
7 "(1) Paragraphs (1), (5), and (19) of sub-
8 section (b) shall not apply.
9 "(2) Paragraph (7) of subsection (b) shall apply
10 by treating all services as not covered by the retire-
11 ment systems referred to in subparagraphs (C) and
12 (F) thereof.
13 "(3) Subsection (e) shall not apply and the
14 term 'State' shall include the District of Columbia.".
15 (c) CONFORMING AMENDMENT.—Subsection (d) of
16 section 3111 of such Code, as redesignated by this section,
17 is amended by striking "this section" and inserting "sub-
18 sections (a) and (b)".
19 (d) APPLICATION TO RAILROADS.—
20 (1) IN GENERAL.—Section 3221 of such Code
21 is amended by redesignating subsection (c) as sub-
22 section (d) and by inserting after subsection (b) the
23 following new subsection:
24 "(c) EMPLOYERS ELECTING TO NOT PROVIDE
25 HEALTH BENEFITS.—

1 "(1) IN GENERAL.—In addition to other taxes,
2 there is hereby imposed on every nonelecting em-
3 ployer an excise tax, with respect to having individ-
4 uals in his employ, equal to 8 percent of the com-
5 pensation paid during any calendar year by such em-
6 ployer for services rendered to such employer.

7 "(2) EXCEPTION FOR SMALL EMPLOYERS.—
8 Rules similar to the rules of section 3111(c)(2) shall
9 apply for purposes of this subsection.

10 "(3) NONELECTING EMPLOYER.—For purposes
11 of paragraph (1), the term 'nonelecting employer'
12 means any employer for any period with respect to
13 which such employer does not have an election under
14 section 4980H(a) in effect.

15 "(4) SPECIAL RULE FOR SEPARATE ELEC-
16 TIONS.—In the case of an employer who makes a
17 separate election described in section 4980H(a)(4)
18 for any period, subsection (a) shall be applied for
19 such period by taking into account only the wages
20 paid to employees who are not subject to such elec-
21 tion.".

22 (2) DEFINITIONS.—Subsection (e) of section
23 3231 of such Code is amended by adding at the end
24 the following new paragraph:

1 "(13) SPECIAL RULES FOR TAX ON EMPLOYERS
2 ELECTING NOT TO PROVIDE HEALTH BENEFITS.—
3 For purposes of section 3221(c)—
4 "(A) Paragraph (1) shall be applied with-
5 out regard to the third sentence thereof.
6 "(B) Paragraph (2) shall not apply.".
7 (3) CONFORMING AMENDMENT.—Subsection (d)
8 of section 3221 of such Code, as redesignated by
9 this section, is amended by striking "subsections (a)
10 and (b), see section 3231(e)(2)" and inserting "this
11 section, see paragraphs (2) and (13)(B) of section
12 3231(e)".
13 (e) EFFECTIVE DATE.—The amendments made by
14 this section shall apply to periods beginning after Decem-
15 ber 31, 2012.

16 Subtitle B—Credit for Small Busi-
17 ness Employee Health Coverage
18 Expenses

19 SEC. 421. CREDIT FOR SMALL BUSINESS EMPLOYEE
20 HEALTH COVERAGE EXPENSES.

21 (a) IN GENERAL.—Subpart D of part IV of sub-
22 chapter A of chapter 1 of the Internal Revenue Code of
23 1986 (relating to business-related credits) is amended by
24 adding at the end the following new section:

1 **"SEC. 45R. SMALL BUSINESS EMPLOYEE HEALTH COV-**
2 **ERAGE CREDIT.**
3 "(a) IN GENERAL.—For purposes of section 38, in
4 the case of a qualified small employer, the small business
5 employee health coverage credit determined under this sec-
6 tion for the taxable year is an amount equal to the applica-
7 ble percentage of the qualified employee health coverage
8 expenses of such employer for such taxable year.
9 "(b) APPLICABLE PERCENTAGE.—
10 "(1) IN GENERAL.—For purposes of this sec-
11 tion, the applicable percentage is 50 percent.
12 "(2) PHASEOUT BASED ON AVERAGE COM-
13 PENSATION OF EMPLOYEES.—In the case of an em-
14 ployer whose average annual employee compensation
15 for the taxable year exceeds $20,000, the percentage
16 specified in paragraph (1) shall be reduced by a
17 number of percentage points which bears the same
18 ratio to 50 as such excess bears to $20,000.
19 "(c) LIMITATIONS.—
20 "(1) PHASEOUT BASED ON EMPLOYER SIZE.—
21 In the case of an employer who employs more than
22 10 qualified employees during the taxable year, the
23 credit determined under subsection (a) shall be re-
24 duced by an amount which bears the same ratio to
25 the amount of such credit (determined without re-

1 gard to this paragraph and after the application of
2 the other provisions of this section) as—
3 ‘‘(A) the excess of—
4 ‘‘(i) the number of qualified employees
5 employed by the employer during the tax-
6 able year, over
7 ‘‘(ii) 10, bears to
8 ‘‘(B) 15.
9 ‘‘(2) CREDIT NOT ALLOWED WITH RESPECT TO
10 CERTAIN HIGHLY COMPENSATED EMPLOYEES.—No
11 credit shall be allowed under subsection (a) with re-
12 spect to qualified employee health coverage expenses
13 paid or incurred with respect to any employee for
14 any taxable year if the aggregate compensation paid
15 by the employer to such employee during such tax-
16 able year exceeds $80,000.
17 ‘‘(d) QUALIFIED EMPLOYEE HEALTH COVERAGE EX-
18 PENSES.—For purposes of this section—
19 ‘‘(1) IN GENERAL.—The term ‘qualified em-
20 ployee health coverage expenses’ means, with respect
21 to any employer for any taxable year, the aggregate
22 amount paid or incurred by such employer during
23 such taxable year for coverage of any qualified em-
24 ployee of the employer (including any family cov-

1 erage which covers such employee) under qualified
2 health coverage.
3 "(2) QUALIFIED HEALTH COVERAGE.—The
4 term 'qualified health coverage' means acceptable
5 coverage (as defined in section 59B(d)) which—
6 "(A) is provided pursuant to an election
7 under section 4980H(a), and
8 "(B) satisfies the requirements referred to
9 in section 4980H(c).
10 "(e) OTHER DEFINITIONS.—For purposes of this
11 section—
12 "(1) QUALIFIED SMALL EMPLOYER.—For pur-
13 poses of this section, the term 'qualified small em-
14 ployer' means any employer for any taxable year
15 if—
16 "(A) the number of qualified employees
17 employed by such employer during the taxable
18 year does not exceed 25, and
19 "(B) the average annual employee com-
20 pensation of such employer for such taxable
21 year does not exceed the sum of the dollar
22 amounts in effect under subsection (b)(2).
23 "(2) QUALIFIED EMPLOYEE.—The term 'quali-
24 fied employee' means any employee of an employer
25 for any taxable year of the employer if such em-

1 ployee received at least $5,000 of compensation from
2 such employer for services performed in the trade or
3 business of such employer during such taxable year.

4 ‘‘(3) AVERAGE ANNUAL EMPLOYEE COMPENSA-
5 TION.—The term ‘average annual employee com-
6 pensation’ means, with respect to any employer for
7 any taxable year, the average amount of compensa-
8 tion paid by such employer to qualified employees of
9 such employer during such taxable year.

10 ‘‘(4) COMPENSATION.—The term ‘compensa-
11 tion’ has the meaning given such term in section
12 408(p)(6)(A).

13 ‘‘(5) FAMILY COVERAGE.—The term ‘family
14 coverage’ means any coverage other than self-only
15 coverage.

16 ‘‘(f) SPECIAL RULES.—For purposes of this sec-
17 tion—

18 ‘‘(1) SPECIAL RULE FOR PARTNERSHIPS AND
19 SELF-EMPLOYED.—In the case of a partnership (or
20 a trade or business carried on by an individual)
21 which has one or more qualified employees (deter-
22 mined without regard to this paragraph) with re-
23 spect to whom the election under 4980H(a) applies,
24 each partner (or, in the case of a trade or business

1 carried on by an individual, such individual) shall be
2 treated as an employee.
3 ''(2) AGGREGATION RULE.—All persons treated
4 as a single employer under subsection (b), (c), (m),
5 or (o) of section 414 shall be treated as 1 employer.
6 ''(3) DENIAL OF DOUBLE BENEFIT.—Any de-
7 duction otherwise allowable with respect to amounts
8 paid or incurred for health insurance coverage to
9 which subsection (a) applies shall be reduced by the
10 amount of the credit determined under this section.
11 ''(4) INFLATION ADJUSTMENT.—In the case of
12 any taxable year beginning after 2013, each of the
13 dollar amounts in subsections (b)(2), (c)(2), and
14 (e)(2) shall be increased by an amount equal to—
15 ''(A) such dollar amount, multiplied by
16 ''(B) the cost of living adjustment deter-
17 mined under section 1(f)(3) for the calendar
18 year in which the taxable year begins deter-
19 mined by substituting 'calendar year 2012' for
20 'calendar year 1992' in subparagraph (B)
21 thereof.
22 If any increase determined under this paragraph is
23 not a multiple of $50, such increase shall be rounded
24 to the next lowest multiple of $50.''.

1 (b) CREDIT TO BE PART OF GENERAL BUSINESS
2 CREDIT.—Subsection (b) of section 38 of such Code (re-
3 lating to general business credit) is amended by striking
4 ‘‘plus’’ at the end of paragraph (34), by striking the period
5 at the end of paragraph (35) and inserting ‘‘, plus’’ , and
6 by adding at the end the following new paragraph:
7 ‘‘(36) in the case of a qualified small employer
8 (as defined in section 45R(e)), the small business
9 employee health coverage credit determined under
10 section 45R(a).’’.
11 (c) CLERICAL AMENDMENT.—The table of sections
12 for subpart D of part IV of subchapter A of chapter 1
13 of such Code is amended by inserting after the item relat-
14 ing to section 45Q the following new item:

‘‘Sec. 45R. Small business employee health coverage credit.’’.

15 (d) EFFECTIVE DATE.—The amendments made by
16 this section shall apply to taxable years beginning after
17 December 31, 2012.

18 Subtitle C—Disclosures to Carry 19 Out Health Insurance Exchange 20 Subsidies

21 SEC. 431. DISCLOSURES TO CARRY OUT HEALTH INSUR- 22 ANCE EXCHANGE SUBSIDIES.

23 (a) IN GENERAL.—Subsection (l) of section 6103 of
24 the Internal Revenue Code of 1986 is amended by adding
25 at the end the following new paragraph:

1 "(21) DISCLOSURE OF RETURN INFORMATION
2 TO CARRY OUT HEALTH INSURANCE EXCHANGE SUB-
3 SIDIES.—
4 "(A) IN GENERAL.—The Secretary, upon
5 written request from the Health Choices Com-
6 missioner or the head of a State-based health
7 insurance exchange approved for operation
8 under section 208 of the America's Affordable
9 Health Choices Act of 2009, shall disclose to of-
10 ficers and employees of the Health Choices Ad-
11 ministration or such State-based health insur-
12 ance exchange, as the case may be, return in-
13 formation of any taxpayer whose income is rel-
14 evant in determining any affordability credit de-
15 scribed in subtitle C of title II of the America's
16 Affordable Health Choices Act of 2009. Such
17 return information shall be limited to—
18 "(i) taxpayer identity information
19 with respect to such taxpayer,
20 "(ii) the filing status of such tax-
21 payer,
22 "(iii) the modified adjusted gross in-
23 come of such taxpayer (as defined in sec-
24 tion 59B(e)(5)),

1 "(iv) the number of dependents of the
2 taxpayer,
3 "(v) such other information as is pre-
4 scribed by the Secretary by regulation as
5 might indicate whether the taxpayer is eli-
6 gible for such affordability credits (and the
7 amount thereof), and
8 "(vi) the taxable year with respect to
9 which the preceding information relates or,
10 if applicable, the fact that such informa-
11 tion is not available.
12 "(B) RESTRICTION ON USE OF DISCLOSED
13 INFORMATION.—Return information disclosed
14 under subparagraph (A) may be used by offi-
15 cers and employees of the Health Choices Ad-
16 ministration or such State-based health insur-
17 ance exchange, as the case may be, only for the
18 purposes of, and to the extent necessary in, es-
19 tablishing and verifying the appropriate amount
20 of any affordability credit described in subtitle
21 C of title II of the America's Affordable Health
22 Choices Act of 2009 and providing for the re-
23 payment of any such credit which was in excess
24 of such appropriate amount.".

1 (b) PROCEDURES AND RECORDKEEPING RELATED
2 TO DISCLOSURES.—Paragraph (4) of section 6103(p) of
3 such Code is amended—
4 (1) by inserting ", or any entity described in
5 subsection (l)(21)," after "or (20)" in the matter
6 preceding subparagraph (A),
7 (2) by inserting "or any entity described in sub-
8 section (l)(21)," after "or (o)(1)(A)" in subpara-
9 graph (F)(ii), and
10 (3) by inserting "or any entity described in sub-
11 section (l)(21)," after "or (20)" both places it ap-
12 pears in the matter after subparagraph (F).
13 (c) UNAUTHORIZED DISCLOSURE OR INSPECTION.—
14 Paragraph (2) of section 7213(a) of such Code is amended
15 by striking "or (20)" and inserting "(20), or (21)".

16 # Subtitle D—Other Revenue
17 # Provisions

18 ## PART 1—GENERAL PROVISIONS

19 ### SEC. 441. SURCHARGE ON HIGH INCOME INDIVIDUALS.

20 (a) IN GENERAL.—Part VIII of subchapter A of
21 chapter 1 of the Internal Revenue Code of 1986, as added
22 by this title, is amended by adding at the end the following
23 new subpart:

24 **"Subpart B—Surcharge on High Income Individuals**

"Sec. 59C. Surcharge on high income individuals.

1 **"SEC. 59C. SURCHARGE ON HIGH INCOME INDIVIDUALS.**

2 "(a) GENERAL RULE.—In the case of a taxpayer
3 other than a corporation, there is hereby imposed (in addi-
4 tion to any other tax imposed by this subtitle) a tax equal
5 to—

6 "(1) 1 percent of so much of the modified ad-
7 justed gross income of the taxpayer as exceeds
8 $350,000 but does not exceed $500,000,

9 "(2) 1.5 percent of so much of the modified ad-
10 justed gross income of the taxpayer as exceeds
11 $500,000 but does not exceed $1,000,000, and

12 "(3) 5.4 percent of so much of the modified ad-
13 justed gross income of the taxpayer as exceeds
14 $1,000,000.

15 "(b) TAXPAYERS NOT MAKING A JOINT RETURN.—
16 In the case of any taxpayer other than a taxpayer making
17 a joint return under section 6013 or a surviving spouse
18 (as defined in section 2(a)), subsection (a) shall be applied
19 by substituting for each of the dollar amounts therein
20 (after any increase determined under subsection (e)) a dol-
21 lar amount equal to—

22 "(1) 50 percent of the dollar amount so in ef-
23 fect in the case of a married individual filing a sepa-
24 rate return, and

25 "(2) 80 percent of the dollar amount so in ef-
26 fect in any other case.

1 "(c) ADJUSTMENTS BASED ON FEDERAL HEALTH
2 REFORM SAVINGS.—
3 "(1) IN GENERAL.—Except as provided in para-
4 graph (2), in the case of any taxable year beginning
5 after December 31, 2012, subsection (a) shall be ap-
6 plied—
7 "(A) by substituting '2 percent' for '1 per-
8 cent', and
9 "(B) by substituting '3 percent' for '1.5
10 percent'.
11 "(2) ADJUSTMENTS BASED ON EXCESS FED-
12 ERAL HEALTH REFORM SAVINGS.—
13 "(A) EXCEPTION IF FEDERAL HEALTH RE-
14 FORM SAVINGS SIGNIFICANTLY EXCEEDS BASE
15 AMOUNT.—If the excess Federal health reform
16 savings is more than $150,000,000,000 but not
17 more than $175,000,000,000, paragraph (1)
18 shall not apply.
19 "(B) FURTHER ADJUSTMENT FOR ADDI-
20 TIONAL FEDERAL HEALTH REFORM SAVINGS.—
21 If the excess Federal health reform savings is
22 more than $175,000,000,000, paragraphs (1)
23 and (2) of subsection (a) (and paragraph (1) of
24 this subsection) shall not apply to any taxable
25 year beginning after December 31, 2012.

1 "(C) EXCESS FEDERAL HEALTH REFORM
2 SAVINGS.—For purposes of this subsection, the
3 term 'excess Federal health reform savings'
4 means the excess of—
5 "(i) the Federal health reform sav-
6 ings, over
7 "(ii) $525,000,000,000.
8 "(D) FEDERAL HEALTH REFORM SAV-
9 INGS.—The term 'Federal health reform sav-
10 ings' means the sum of the amounts described
11 in subparagraphs (A) and (B) of paragraph (3).
12 "(3) DETERMINATION OF FEDERAL HEALTH
13 REFORM SAVINGS.—Not later than December 1,
14 2012, the Director of the Office of Management and
15 Budget shall—
16 "(A) determine, on the basis of the study
17 conducted under paragraph (4), the aggregate
18 reductions in Federal expenditures which have
19 been achieved as a result of the provisions of,
20 and amendments made by, division B of the
21 America's Affordable Health Choices Act of
22 2009 during the period beginning on October 1,
23 2009, and ending with the latest date with re-
24 spect to which the Director has sufficient data
25 to make such determination, and

1 “(B) estimate, on the basis of such study
2 and the determination under subparagraph (A),
3 the aggregate reductions in Federal expendi-
4 tures which will be achieved as a result of such
5 provisions and amendments during so much of
6 the period beginning with fiscal year 2010 and
7 ending with fiscal year 2019 as is not taken
8 into account under subparagraph (A).
9 “(4) STUDY OF FEDERAL HEALTH REFORM
10 SAVINGS.—The Director of the Office of Manage-
11 ment and Budget shall conduct a study of the reduc-
12 tions in Federal expenditures during fiscal years
13 2010 through 2019 which are attributable to the
14 provisions of, and amendments made by, division B
15 of the America’s Affordable Health Choices Act of
16 2009. The Director shall complete such study not
17 later than December 1, 2012.
18 “(5) REDUCTIONS IN FEDERAL EXPENDITURES
19 DETERMINED WITHOUT REGARD TO PROGRAM IN-
20 VESTMENTS.—For purposes of paragraphs (3) and
21 (4), reductions in Federal expenditures shall be de-
22 termined without regard to section 1121 of the
23 America’s Affordable Health Choices Act of 2009
24 and other program investments under division B
25 thereof.

1 "(d) MODIFIED ADJUSTED GROSS INCOME.—For
2 purposes of this section, the term 'modified adjusted gross
3 income' means adjusted gross income reduced by any de-
4 duction (not taken into account in determining adjusted
5 gross income) allowed for investment interest (as defined
6 in section 163(d)). In the case of an estate or trust, ad-
7 justed gross income shall be determined as provided in sec-
8 tion 67(e).

9 "(e) INFLATION ADJUSTMENTS.—

10 "(1) IN GENERAL.—In the case of taxable years
11 beginning after 2011, the dollar amounts in sub-
12 section (a) shall be increased by an amount equal
13 to—

14 "(A) such dollar amount, multiplied by

15 "(B) the cost-of-living adjustment deter-
16 mined under section 1(f)(3) for the calendar
17 year in which the taxable year begins, by sub-
18 stituting 'calendar year 2010' for 'calendar year
19 1992' in subparagraph (B) thereof.

20 "(2) ROUNDING.—If any amount as adjusted
21 under paragraph (1) is not a multiple of $5,000,
22 such amount shall be rounded to the next lowest
23 multiple of $5,000.

24 "(f) SPECIAL RULES.—

1 "(1) NONRESIDENT ALIEN.—In the case of a
2 nonresident alien individual, only amounts taken
3 into account in connection with the tax imposed
4 under section 871(b) shall be taken into account
5 under this section.
6 "(2) CITIZENS AND RESIDENTS LIVING
7 ABROAD.—The dollar amounts in effect under sub-
8 section (a) (after the application of subsections (b)
9 and (e)) shall be decreased by the excess of—
10 "(A) the amounts excluded from the tax-
11 payer's gross income under section 911, over
12 "(B) the amounts of any deductions or ex-
13 clusions disallowed under section 911(d)(6)
14 with respect to the amounts described in sub-
15 paragraph (A).
16 "(3) CHARITABLE TRUSTS.—Subsection (a)
17 shall not apply to a trust all the unexpired interests
18 in which are devoted to one or more of the purposes
19 described in section 170(c)(2)(B).
20 "(4) NOT TREATED AS TAX IMPOSED BY THIS
21 CHAPTER FOR CERTAIN PURPOSES.—The tax im-
22 posed under this section shall not be treated as tax
23 imposed by this chapter for purposes of determining
24 the amount of any credit under this chapter or for
25 purposes of section 55.".

1 (b) CLERICAL AMENDMENT.—The table of subparts
2 for part VIII of subchapter A of chapter 1 of such Code,
3 as added by this title, is amended by inserting after the
4 item relating to subpart A the following new item:

"SUBPART B. SURCHARGE ON HIGH INCOME INDIVIDUALS.".

5 (c) SECTION 15 NOT TO APPLY.—The amendment
6 made by subsection (a) shall not be treated as a change
7 in a rate of tax for purposes of section 15 of the Internal
8 Revenue Code of 1986.

9 (d) EFFECTIVE DATE.—The amendments made by
10 this section shall apply to taxable years beginning after
11 December 31, 2010.

12 **SEC. 442. DISTRIBUTIONS FOR MEDICINE QUALIFIED ONLY**
13 **IF FOR PRESCRIBED DRUG OR INSULIN.**

14 (a) HSAS.—Subparagraph (A) of section 223(d)(2)
15 of the Internal Revenue Code of 1986 is amended by add-
16 ing at the end the following: "Such term shall include an
17 amount paid for medicine or a drug only if such medicine
18 or drug is a prescribed drug or is insulin.".

19 (b) ARCHER MSAS.—Subparagraph (A) of section
20 220(d)(2) of such Code is amended by adding at the end
21 the following: "Such term shall include an amount paid
22 for medicine or a drug only if such medicine or drug is
23 a prescribed drug or is insulin.".

24 (c) HEALTH FLEXIBLE SPENDING ARRANGEMENTS
25 AND HEALTH REIMBURSEMENT ARRANGEMENTS.—Sec-

1 tion 106 of such Code is amended by adding at the end
2 the following new subsection:
3 ''(f) REIMBURSEMENTS FOR MEDICINE RESTRICTED
4 TO PRESCRIBED DRUGS AND INSULIN.—For purposes of
5 this section and section 105, reimbursement for expenses
6 incurred for a medicine or a drug shall be treated as a
7 reimbursement for medical expenses only if such medicine
8 or drug is a prescribed drug or is insulin.''.
9 (d) EFFECTIVE DATES.—The amendment made by
10 this section shall apply to expenses incurred after Decem-
11 ber 31, 2009.

12 **SEC. 443. DELAY IN APPLICATION OF WORLDWIDE ALLOCA-**
13 **TION OF INTEREST.**

14 (a) IN GENERAL.—Paragraphs (5)(D) and (6) of sec-
15 tion 864(f) of the Internal Revenue Code of 1986 are each
16 amended by striking ''December 31, 2010'' and inserting
17 ''December 31, 2019''.
18 (b) TRANSITION.—Subsection (f) of section 864 of
19 such Code is amended by striking paragraph (7).

20 **PART 2—PREVENTION OF TAX AVOIDANCE**

21 **SEC. 451. LIMITATION ON TREATY BENEFITS FOR CERTAIN**
22 **DEDUCTIBLE PAYMENTS.**

23 (a) IN GENERAL.—Section 894 of the Internal Rev-
24 enue Code of 1986 (relating to income affected by treaty)

1 is amended by adding at the end the following new sub-
2 section:

3 "(d) LIMITATION ON TREATY BENEFITS FOR CER-
4 TAIN DEDUCTIBLE PAYMENTS.—

5 "(1) IN GENERAL.—In the case of any deduct-
6 ible related-party payment, any withholding tax im-
7 posed under chapter 3 (and any tax imposed under
8 subpart A or B of this part) with respect to such
9 payment may not be reduced under any treaty of the
10 United States unless any such withholding tax would
11 be reduced under a treaty of the United States if
12 such payment were made directly to the foreign par-
13 ent corporation.

14 "(2) DEDUCTIBLE RELATED-PARTY PAY-
15 MENT.—For purposes of this subsection, the term
16 'deductible related-party payment' means any pay-
17 ment made, directly or indirectly, by any person to
18 any other person if the payment is allowable as a de-
19 duction under this chapter and both persons are
20 members of the same foreign controlled group of en-
21 tities.

22 "(3) FOREIGN CONTROLLED GROUP OF ENTI-
23 TIES.—For purposes of this subsection—

24 "(A) IN GENERAL.—The term 'foreign
25 controlled group of entities' means a controlled

1 group of entities the common parent of which
2 is a foreign corporation.
3 "(B) CONTROLLED GROUP OF ENTITIES.—
4 The term 'controlled group of entities' means a
5 controlled group of corporations as defined in
6 section 1563(a)(1), except that—
7 "(i) 'more than 50 percent' shall be
8 substituted for 'at least 80 percent' each
9 place it appears therein, and
10 "(ii) the determination shall be made
11 without regard to subsections (a)(4) and
12 (b)(2) of section 1563.
13 A partnership or any other entity (other than a
14 corporation) shall be treated as a member of a
15 controlled group of entities if such entity is con-
16 trolled (within the meaning of section
17 954(d)(3)) by members of such group (includ-
18 ing any entity treated as a member of such
19 group by reason of this sentence).
20 "(4) FOREIGN PARENT CORPORATION.—For
21 purposes of this subsection, the term 'foreign parent
22 corporation' means, with respect to any deductible
23 related-party payment, the common parent of the
24 foreign controlled group of entities referred to in
25 paragraph (3)(A).

1 "(5) REGULATIONS.—The Secretary may pre-
2 scribe such regulations or other guidance as are nec-
3 essary or appropriate to carry out the purposes of
4 this subsection, including regulations or other guid-
5 ance which provide for—
6 "(A) the treatment of two or more persons
7 as members of a foreign controlled group of en-
8 tities if such persons would be the common par-
9 ent of such group if treated as one corporation,
10 and
11 "(B) the treatment of any member of a
12 foreign controlled group of entities as the com-
13 mon parent of such group if such treatment is
14 appropriate taking into account the economic
15 relationships among such entities.".
16 (b) EFFECTIVE DATE.—The amendment made by
17 this section shall apply to payments made after the date
18 of the enactment of this Act.

19 **SEC. 452. CODIFICATION OF ECONOMIC SUBSTANCE DOC-**
20 **TRINE.**

21 (a) IN GENERAL.—Section 7701 of the Internal Rev-
22 enue Code of 1986 is amended by redesignating subsection
23 (o) as subsection (p) and by inserting after subsection (n)
24 the following new subsection:

1 "(o) CLARIFICATION OF ECONOMIC SUBSTANCE
2 DOCTRINE.—
3 "(1) APPLICATION OF DOCTRINE.—In the case
4 of any transaction to which the economic substance
5 doctrine is relevant, such transaction shall be treated
6 as having economic substance only if—
7 "(A) the transaction changes in a mean-
8 ingful way (apart from Federal income tax ef-
9 fects) the taxpayer's economic position, and
10 "(B) the taxpayer has a substantial pur-
11 pose (apart from Federal income tax effects)
12 for entering into such transaction.
13 "(2) SPECIAL RULE WHERE TAXPAYER RELIES
14 ON PROFIT POTENTIAL.—
15 "(A) IN GENERAL.—The potential for
16 profit of a transaction shall be taken into ac-
17 count in determining whether the requirements
18 of subparagraphs (A) and (B) of paragraph (1)
19 are met with respect to the transaction only if
20 the present value of the reasonably expected
21 pre-tax profit from the transaction is substan-
22 tial in relation to the present value of the ex-
23 pected net tax benefits that would be allowed if
24 the transaction were respected.

1 "(B) TREATMENT OF FEES AND FOREIGN
2 TAXES.—Fees and other transaction expenses
3 and foreign taxes shall be taken into account as
4 expenses in determining pre-tax profit under
5 subparagraph (A).
6 "(3) STATE AND LOCAL TAX BENEFITS.—For
7 purposes of paragraph (1), any State or local income
8 tax effect which is related to a Federal income tax
9 effect shall be treated in the same manner as a Fed-
10 eral income tax effect.
11 "(4) FINANCIAL ACCOUNTING BENEFITS.—For
12 purposes of paragraph (1)(B), achieving a financial
13 accounting benefit shall not be taken into account as
14 a purpose for entering into a transaction if the ori-
15 gin of such financial accounting benefit is a reduc-
16 tion of Federal income tax.
17 "(5) DEFINITIONS AND SPECIAL RULES.—For
18 purposes of this subsection—
19 "(A) ECONOMIC SUBSTANCE DOCTRINE.—
20 The term 'economic substance doctrine' means
21 the common law doctrine under which tax bene-
22 fits under subtitle A with respect to a trans-
23 action are not allowable if the transaction does
24 not have economic substance or lacks a business
25 purpose.

1 "(B) EXCEPTION FOR PERSONAL TRANS-
2 ACTIONS OF INDIVIDUALS.—In the case of an
3 individual, paragraph (1) shall apply only to
4 transactions entered into in connection with a
5 trade or business or an activity engaged in for
6 the production of income.
7 "(C) OTHER COMMON LAW DOCTRINES
8 NOT AFFECTED.—Except as specifically pro-
9 vided in this subsection, the provisions of this
10 subsection shall not be construed as altering or
11 supplanting any other rule of law, and the re-
12 quirements of this subsection shall be construed
13 as being in addition to any such other rule of
14 law.
15 "(D) DETERMINATION OF APPLICATION OF
16 DOCTRINE NOT AFFECTED.—The determination
17 of whether the economic substance doctrine is
18 relevant to a transaction (or series of trans-
19 actions) shall be made in the same manner as
20 if this subsection had never been enacted.
21 "(6) REGULATIONS.—The Secretary shall pre-
22 scribe such regulations as may be necessary or ap-
23 propriate to carry out the purposes of this sub-
24 section.".

1 (b) EFFECTIVE DATE.—The amendments made by
2 this section shall apply to transactions entered into after
3 the date of the enactment of this Act.

4 **SEC. 453. PENALTIES FOR UNDERPAYMENTS.**

5 (a) PENALTY FOR UNDERPAYMENTS ATTRIBUTABLE
6 TO TRANSACTIONS LACKING ECONOMIC SUBSTANCE.—
7 (1) IN GENERAL.—Subsection (b) of section
8 6662 of the Internal Revenue Code of 1986 is
9 amended by inserting after paragraph (5) the fol-
10 lowing new paragraph:
11 ''(6) Any disallowance of claimed tax benefits
12 by reason of a transaction lacking economic sub-
13 stance (within the meaning of section 7701(o)) or
14 failing to meet the requirements of any similar rule
15 of law.''.
16 (2) INCREASED PENALTY FOR NONDISCLOSED
17 TRANSACTIONS.—Section 6662 of such Code is
18 amended by adding at the end the following new
19 subsection:
20 ''(i) INCREASE IN PENALTY IN CASE OF NONDIS-
21 CLOSED NONECONOMIC SUBSTANCE TRANSACTIONS.—
22 ''(1) IN GENERAL.—In the case of any portion
23 of an underpayment which is attributable to one or
24 more nondisclosed noneconomic substance trans-
25 actions, subsection (a) shall be applied with respect

1 to such portion by substituting '40 percent' for '20
2 percent'.
3 "(2) NONDISCLOSED NONECONOMIC SUB-
4 STANCE TRANSACTIONS.—For purposes of this sub-
5 section, the term 'nondisclosed noneconomic sub-
6 stance transaction' means any portion of a trans-
7 action described in subsection (b)(6) with respect to
8 which the relevant facts affecting the tax treatment
9 are not adequately disclosed in the return nor in a
10 statement attached to the return.
11 "(3) SPECIAL RULE FOR AMENDED RE-
12 TURNS.—Except as provided in regulations, in no
13 event shall any amendment or supplement to a re-
14 turn of tax be taken into account for purposes of
15 this subsection if the amendment or supplement is
16 filed after the earlier of the date the taxpayer is first
17 contacted by the Secretary regarding the examina-
18 tion of the return or such other date as is specified
19 by the Secretary.".
20 (3) CONFORMING AMENDMENT.—Subparagraph
21 (B) of section 6662A(e)(2) of such Code is amend-
22 ed—
23 (A) by striking "section 6662(h)" and in-
24 serting "subsections (h) or (i) of section 6662",
25 and

1 (B) by striking "GROSS VALUATION
2 MISSTATEMENT PENALTY" in the heading and
3 inserting "CERTAIN INCREASED UNDER-
4 PAYMENT PENALTIES".

5 (b) REASONABLE CAUSE EXCEPTION NOT APPLICA-
6 BLE TO NONECONOMIC SUBSTANCE TRANSACTIONS, TAX
7 SHELTERS, AND CERTAIN LARGE OR PUBLICLY TRADED
8 PERSONS.—Subsection (c) of section 6664 of such Code
9 is amended—

10 (1) by redesignating paragraphs (2) and (3) as
11 paragraphs (3) and (4), respectively,

12 (2) by striking "paragraph (2)" in paragraph
13 (4), as so redesignated, and inserting "paragraph
14 (3)", and

15 (3) by inserting after paragraph (1) the fol-
16 lowing new paragraph:

17 "(2) EXCEPTION.—Paragraph (1) shall not
18 apply to—

19 "(A) to any portion of an underpayment
20 which is attributable to one or more tax shelters
21 (as defined in section 6662(d)(2)(C)) or trans-
22 actions described in section 6662(b)(6), and

23 "(B) to any taxpayer if such taxpayer is a
24 specified person (as defined in section
25 6662(d)(2)(D)(ii)).".

1 (c) APPLICATION OF PENALTY FOR ERRONEOUS
2 CLAIM FOR REFUND OR CREDIT TO NONECONOMIC SUB-
3 STANCE TRANSACTIONS.—Section 6676 of such Code is
4 amended by redesignating subsection (c) as subsection (d)
5 and inserting after subsection (b) the following new sub-
6 section:

7 "(c) NONECONOMIC SUBSTANCE TRANSACTIONS
8 TREATED AS LACKING REASONABLE BASIS.—For pur-
9 poses of this section, any excessive amount which is attrib-
10 utable to any transaction described in section 6662(b)(6)
11 shall not be treated as having a reasonable basis.".

12 (d) SPECIAL UNDERSTATEMENT REDUCTION RULE
13 FOR CERTAIN LARGE OR PUBLICLY TRADED PERSONS.—

14 (1) IN GENERAL.—Paragraph (2) of section
15 6662(d) of such Code is amended by adding at the
16 end the following new subparagraph:

17 "(D) SPECIAL REDUCTION RULE FOR CER-
18 TAIN LARGE OR PUBLICLY TRADED PERSONS.—

19 "(i) IN GENERAL.—In the case of any
20 specified person—

21 "(I) subparagraph (B) shall not
22 apply, and

23 "(II) the amount of the under-
24 statement under subparagraph (A)
25 shall be reduced by that portion of the

1 understatement which is attributable
2 to any item with respect to which the
3 taxpayer has a reasonable belief that
4 the tax treatment of such item by the
5 taxpayer is more likely than not the
6 proper tax treatment of such item.
7 ''(ii) SPECIFIED PERSON.—For pur-
8 poses of this subparagraph, the term 'spec-
9 ified person' means—
10 ''(I) any person required to file
11 periodic or other reports under section
12 13 of the Securities Exchange Act of
13 1934, and
14 ''(II) any corporation with gross
15 receipts in excess of $100,000,000 for
16 the taxable year involved.
17 All persons treated as a single employer
18 under section 52(a) shall be treated as one
19 person for purposes of subclause (II).''.
20 (2) CONFORMING AMENDMENT.—Subparagraph
21 (C) of section 6662(d)(2) of such Code is amended
22 by striking ''Subparagraph (B)'' and inserting ''Sub-
23 paragraphs (B) and (D)(i)(II)''.

1 (e) EFFECTIVE DATE.—The amendments made by
2 this section shall apply to transactions entered into after
3 the date of the enactment of this Act.

4 **PART 3—PARITY IN HEALTH BENEFITS**

5 **SEC. 461. CERTAIN HEALTH RELATED BENEFITS APPLICA-**
6 **BLE TO SPOUSES AND DEPENDENTS EX-**
7 **TENDED TO ELIGIBLE BENEFICIARIES.**

8 (a) APPLICATION OF ACCIDENT AND HEALTH PLANS
9 TO ELIGIBLE BENEFICIARIES.—
10 (1) EXCLUSION OF CONTRIBUTIONS.—Section
11 106 of the Internal Revenue Code of 1986 (relating
12 to contributions by employer to accident and health
13 plans) is amended by adding at the end the following
14 new subsection:
15 ''(f) COVERAGE PROVIDED FOR ELIGIBLE BENE-
16 FICIARIES OF EMPLOYEES.—
17 ''(1) IN GENERAL.—Subsection (a) shall apply
18 with respect to any eligible beneficiary of the em-
19 ployee.
20 ''(2) ELIGIBLE BENEFICIARY.—For purposes of
21 this subsection, the term 'eligible beneficiary' means
22 any individual who is eligible to receive benefits or
23 coverage under an accident or health plan.''.
24 (2) EXCLUSION OF AMOUNTS EXPENDED FOR
25 MEDICAL CARE.—The first sentence of section

1 105(b) of such Code (relating to amounts expended
2 for medical care) is amended—
3 (A) by striking "and his dependents" and
4 inserting "his dependents", and
5 (B) by inserting before the period the fol-
6 lowing: "and any eligible beneficiary (within the
7 meaning of section 106(f)) with respect to the
8 taxpayer".
9 (3) PAYROLL TAXES.—
10 (A) Section 3121(a)(2) of such Code is
11 amended—
12 (i) by striking "or any of his depend-
13 ents" in the matter preceding subpara-
14 graph (A) and inserting ", any of his de-
15 pendents, or any eligible beneficiary (with-
16 in the meaning of section 106(f)) with re-
17 spect to the employee",
18 (ii) by striking "or any of his depend-
19 ents," in subparagraph (A) and inserting
20 ", any of his dependents, or any eligible
21 beneficiary (within the meaning of section
22 106(f)) with respect to the employee,", and
23 (iii) by striking "and their depend-
24 ents" both places it appears and inserting
25 "and such employees' dependents and eligi-

1 ble beneficiaries (within the meaning of
2 section 106(f))''.
3 (B) Section 3231(e)(1) of such Code is
4 amended—
5 (i) by striking ''or any of his depend-
6 ents'' and inserting '', any of his depend-
7 ents, or any eligible beneficiary (within the
8 meaning of section 106(f)) with respect to
9 the employee,'', and
10 (ii) by striking ''and their depend-
11 ents'' both places it appears and inserting
12 ''and such employees' dependents and eligi-
13 ble beneficiaries (within the meaning of
14 section 106(f))''.
15 (C) Section 3306(b)(2) of such Code is
16 amended—
17 (i) by striking ''or any of his depend-
18 ents'' in the matter preceding subpara-
19 graph (A) and inserting '', any of his de-
20 pendents, or any eligible beneficiary (with-
21 in the meaning of section 106(f)) with re-
22 spect to the employee,'',
23 (ii) by striking ''or any of his depend-
24 ents'' in subparagraph (A) and inserting '',
25 any of his dependents, or any eligible bene-

1 ficiary (within the meaning of section
2 106(f)) with respect to the employee'', and
3 (iii) by striking ''and their depend-
4 ents'' both places it appears and inserting
5 ''and such employees' dependents and eligi-
6 ble beneficiaries (within the meaning of
7 section 106(f))''.
8 (D) Section 3401(a) of such Code is
9 amended by striking ''or'' at the end of para-
10 graph (22), by striking the period at the end of
11 paragraph (23) and inserting ''; or'', and by in-
12 serting after paragraph (23) the following new
13 paragraph:
14 ''(24) for any payment made to or for the ben-
15 efit of an employee or any eligible beneficiary (within
16 the meaning of section 106(f)) if at the time of such
17 payment it is reasonable to believe that the employee
18 will be able to exclude such payment from income
19 under section 106 or under section 105 by reference
20 in section 105(b) to section 106(f).''.
21 (b) EXPANSION OF DEPENDENCY FOR PURPOSES OF
22 DEDUCTION FOR HEALTH INSURANCE COSTS OF SELF-
23 EMPLOYED INDIVIDUALS.—
24 (1) IN GENERAL.—Paragraph (1) of section
25 162(l) of the Internal Revenue Code of 1986 (relat-

1 ing to special rules for health insurance costs of self-
2 employed individuals) is amended to read as follows:
3 "(1) ALLOWANCE OF DEDUCTION.—In the case
4 of a taxpayer who is an employee within the mean-
5 ing of section 401(c)(1), there shall be allowed as a
6 deduction under this section an amount equal to the
7 amount paid during the taxable year for insurance
8 which constitutes medical care for—
9 "(A) the taxpayer,
10 "(B) the taxpayer's spouse,
11 "(C) the taxpayer's dependents, and
12 "(D) any individual who—
13 "(i) satisfies the age requirements of
14 section 152(c)(3)(A),
15 "(ii) bears a relationship to the tax-
16 payer described in section 152(d)(2)(H),
17 and
18 "(iii) meets the requirements of sec-
19 tion 152(d)(1)(C), and
20 "(E) one individual who—
21 "(i) does not satisfy the age require-
22 ments of section 152(c)(3)(A),
23 "(ii) bears a relationship to the tax-
24 payer described in section 152(d)(2)(H),

1 "(iii) meets the requirements of sec-
2 tion 152(d)(1)(D), and
3 "(iv) is not the spouse of the taxpayer
4 and does not bear any relationship to the
5 taxpayer described in subparagraphs (A)
6 through (G) of section 152(d)(2).".
7 (2) CONFORMING AMENDMENT.—Subparagraph
8 (B) of section 162(l)(2) of such Code is amended by
9 inserting ", any dependent, or individual described
10 in subparagraph (D) or (E) of paragraph (1) with
11 respect to" after "spouse".
12 (c) EXTENSION TO ELIGIBLE BENEFICIARIES OF
13 SICK AND ACCIDENT BENEFITS PROVIDED TO MEMBERS
14 OF A VOLUNTARY EMPLOYEES' BENEFICIARY ASSOCIA-
15 TION AND THEIR DEPENDENTS.—Section 501(c)(9) of
16 the Internal Revenue Code of 1986 (relating to list of ex-
17 empt organizations) is amended by adding at the end the
18 following new sentence: "For purposes of providing for the
19 payment of sick and accident benefits to members of such
20 an association and their dependents, the term 'dependents'
21 shall include any individual who is an eligible beneficiary
22 (within the meaning of section 106(f)), as determined
23 under the terms of a medical benefit, health insurance,
24 or other program under which members and their depend-
25 ents are entitled to sick and accident benefits.".

1 (d) FLEXIBLE SPENDING ARRANGEMENTS AND
2 HEALTH REIMBURSEMENT ARRANGEMENTS.—The Sec-
3 retary of Treasury shall issue guidance of general applica-
4 bility providing that medical expenses that otherwise qual-
5 ify—
6 (1) for reimbursement from a flexible spending
7 arrangement under regulations in effect on the date
8 of the enactment of this Act may be reimbursed
9 from an employee's flexible spending arrangement,
10 notwithstanding the fact that such expenses are at-
11 tributable to any individual who is not the employ-
12 ee's spouse or dependent (within the meaning of sec-
13 tion 105(b) of the Internal Revenue Code of 1986)
14 but is an eligible beneficiary (within the meaning of
15 section 106(f) of such Code) under the flexible
16 spending arrangement with respect to the employee,
17 and
18 (2) for reimbursement from a health reimburse-
19 ment arrangement under regulations in effect on the
20 date of the enactment of this Act may be reimbursed
21 from an employee's health reimbursement arrange-
22 ment, notwithstanding the fact that such expenses
23 are attributable to an individual who is not a spouse
24 or dependent (within the meaning of section 105(b)
25 of such Code) but is an eligible beneficiary (within

1 the meaning of section 106(f) of such Code) under
2 the health reimbursement arrangement with respect
3 to the employee.

4 (e) EFFECTIVE DATE.—The amendments made by
5 this section shall apply to taxable years beginning after
6 December 31, 2009.

7 DIVISION B—MEDICARE AND 8 MEDICAID IMPROVEMENTS

9 SEC. 1001. TABLE OF CONTENTS OF DIVISION.

10 The table of contents for this division is as follows:

DIVISION B—MEDICARE AND MEDICAID IMPROVEMENTS

Sec. 1001. Table of contents of division.

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Subtitle A—Provisions Related to Medicare Part A

PART 1—MARKET BASKET UPDATES

Sec. 1101. Skilled nursing facility payment update.
Sec. 1102. Inpatient rehabilitation facility payment update.
Sec. 1103. Incorporating productivity improvements into market basket updates that do not already incorporate such improvements.

PART 2—OTHER MEDICARE PART A PROVISIONS

Sec. 1111. Payments to skilled nursing facilities.
Sec. 1112. Medicare DSH report and payment adjustments in response to coverage expansion.
Sec. 1113. Extension of hospice regulation moratorium.

Subtitle B—Provisions Related to Part B

PART 1—PHYSICIANS' SERVICES

Sec. 1121. Sustainable growth rate reform.
Sec. 1122. Misvalued codes under the physician fee schedule.
Sec. 1123. Payments for efficient areas.
Sec. 1124. Modifications to the Physician Quality Reporting Initiative (PQRI).
Sec. 1125. Adjustment to Medicare payment localities.

PART 2—MARKET BASKET UPDATES

Sec. 1131. Incorporating productivity improvements into market basket updates that do not already incorporate such improvements.

PART 3—OTHER PROVISIONS

Sec. 1141. Rental and purchase of power-driven wheelchairs.
Sec. 1142. Extension of payment rule for brachytherapy.
Sec. 1143. Home infusion therapy report to congress.
Sec. 1144. Require ambulatory surgical centers (ASCs) to submit cost data and other data.
Sec. 1145. Treatment of certain cancer hospitals.
Sec. 1146. Medicare Improvement Fund.
Sec. 1147. Payment for imaging services.
Sec. 1148. Durable medical equipment program improvements.
Sec. 1149. MedPAC study and report on bone mass measurement.

Subtitle C—Provisions Related to Medicare Parts A and B

Sec. 1151. Reducing potentially preventable hospital readmissions.
Sec. 1152. Post acute care services payment reform plan and bundling pilot program.
Sec. 1153. Home health payment update for 2010.
Sec. 1154. Payment adjustments for home health care.
Sec. 1155. Incorporating productivity improvements into market basket update for home health services.
Sec. 1156. Limitation on Medicare exceptions to the prohibition on certain physician referrals made to hospitals.
Sec. 1157. Institute of Medicine study of geographic adjustment factors under Medicare.
Sec. 1158. Revision of medicare payment systems to address geographic inequities.
Sec. 1159. Institute of Medicine study of geographic variation in health care spending and promoting high-value health care.

Subtitle D—Medicare Advantage Reforms

PART 1—PAYMENT AND ADMINISTRATION

Sec. 1161. Phase-in of payment based on fee-for-service costs.
Sec. 1162. Quality bonus payments.
Sec. 1163. Extension of Secretarial coding intensity adjustment authority.
Sec. 1164. Simplification of annual beneficiary election periods.
Sec. 1165. Extension of reasonable cost contracts.
Sec. 1166. Limitation of waiver authority for employer group plans.
Sec. 1167. Improving risk adjustment for payments.
Sec. 1168. Elimination of MA Regional Plan Stabilization Fund.

PART 2—BENEFICIARY PROTECTIONS AND ANTI-FRAUD

Sec. 1171. Limitation on cost-sharing for individual health services.
Sec. 1172. Continuous open enrollment for enrollees in plans with enrollment suspension.
Sec. 1173. Information for beneficiaries on MA plan administrative costs.
Sec. 1174. Strengthening audit authority.
Sec. 1175. Authority to deny plan bids.

PART 3—TREATMENT OF SPECIAL NEEDS PLANS

Sec. 1176. Limitation on enrollment outside open enrollment period of individuals into chronic care specialized MA plans for special needs individuals.
Sec. 1177. Extension of authority of special needs plans to restrict enrollment.

Subtitle E—Improvements to Medicare Part D

Sec. 1181. Elimination of coverage gap.
Sec. 1182. Discounts for certain part D drugs in original coverage gap.
Sec. 1183. Repeal of provision relating to submission of claims by pharmacies located in or contracting with long-term care facilities.
Sec. 1184. Including costs incurred by AIDS drug assistance programs and Indian Health Service in providing prescription drugs toward the annual out-of-pocket threshold under part D.
Sec. 1185. Permitting mid-year changes in enrollment for formulary changes that adversely impact an enrollee.

Subtitle F—Medicare Rural Access Protections

Sec. 1191. Telehealth expansion and enhancements.
Sec. 1192. Extension of outpatient hold harmless provision.
Sec. 1193. Extension of section 508 hospital reclassifications.
Sec. 1194. Extension of geographic floor for work.
Sec. 1195. Extension of payment for technical component of certain physician pathology services.
Sec. 1196. Extension of ambulance add-ons.

TITLE II—MEDICARE BENEFICIARY IMPROVEMENTS

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

Sec. 1201. Improving assets tests for Medicare Savings Program and low-income subsidy program.
Sec. 1202. Elimination of part D cost-sharing for certain non-institutionalized full-benefit dual eligible individuals.
Sec. 1203. Eliminating barriers to enrollment.
Sec. 1204. Enhanced oversight relating to reimbursements for retroactive low income subsidy enrollment.
Sec. 1205. Intelligent assignment in enrollment.
Sec. 1206. Special enrollment period and automatic enrollment process for certain subsidy eligible individuals.
Sec. 1207. Application of MA premiums prior to rebate in calculation of low income subsidy benchmark.

Subtitle B—Reducing Health Disparities

Sec. 1221. Ensuring effective communication in Medicare.
Sec. 1222. Demonstration to promote access for Medicare beneficiaries with limited English proficiency by providing reimbursement for culturally and linguistically appropriate services.
Sec. 1223. IOM report on impact of language access services.
Sec. 1224. Definitions.

Subtitle C—Miscellaneous Improvements

Sec. 1231. Extension of therapy caps exceptions process.

Sec. 1232. Extended months of coverage of immunosuppressive drugs for kidney transplant patients and other renal dialysis provisions.
Sec. 1233. Advance care planning consultation.
Sec. 1234. Part B special enrollment period and waiver of limited enrollment penalty for TRICARE beneficiaries.
Sec. 1235. Exception for use of more recent tax year in case of gains from sale of primary residence in computing part B income-related premium.
Sec. 1236. Demonstration program on use of patient decisions aids.

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

Sec. 1301. Accountable Care Organization pilot program.
Sec. 1302. Medical home pilot program.
Sec. 1303. Payment incentive for selected primary care services.
Sec. 1304. Increased reimbursement rate for certified nurse-midwives.
Sec. 1305. Coverage and waiver of cost-sharing for preventive services.
Sec. 1306. Waiver of deductible for colorectal cancer screening tests regardless of coding, subsequent diagnosis, or ancillary tissue removal.
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Sec. 1611. Enhanced penalties for false statements on provider or supplier enrollment applications.
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Sec. 1631. Enhanced CMS program protection authority.
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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.
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Sec. 1639. Face to face encounter with patient required before physicians may certify eligibility for home health services or durable medical equipment under Medicare.
Sec. 1640. Extension of testimonial subpoena authority to program exclusion investigations.
Sec. 1641. Required repayments of Medicare and Medicaid overpayments.
Sec. 1642. Expanded application of hardship waivers for OIG exclusions to beneficiaries of any Federal health care program.
Sec. 1643. Access to certain information on renal dialysis facilities.
Sec. 1644. Billing agents, clearinghouses, or other alternate payees required to register under Medicare.
Sec. 1645. Conforming civil monetary penalties to False Claims Act amendments.

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

Sec. 1651. Access to Information Necessary to Identify Fraud, Waste, and Abuse.
Sec. 1652. Elimination of duplication between the Healthcare Integrity and Protection Data Bank and the National Practitioner Data Bank.
Sec. 1653. Compliance with HIPAA privacy and security standards.

TITLE VII—MEDICAID AND CHIP

TITLE VIII—REVENUE-RELATED PROVISIONS

Sec. 1801. Disclosures to facilitate identification of individuals likely to be ineligible for the low-income assistance under the Medicare prescription drug program to assist Social Security Administration's outreach to eligible individuals.
Sec. 1802. Comparative Effectiveness Research Trust Fund; financing for Trust Fund.

TITLE IX—MISCELLANEOUS PROVISIONS

Sec. 1901. Repeal of trigger provision.
Sec. 1902. Repeal of comparative cost adjustment (CCA) program.
Sec. 1903. Extension of gainsharing demonstration.
Sec. 1904. Grants to States for quality home visitation programs for families with young children and families expecting children.
Sec. 1905. Improved coordination and protection for dual eligibles.
Sec. 1906. Assessment of Medicare cost-intensive diseases and conditions.

1 # TITLE I—IMPROVING HEALTH
2 # CARE VALUE

3 ## Subtitle A—Provisions Related to
4 ## Medicare Part A

5 ### PART 1—MARKET BASKET UPDATES

6 #### SEC. 1101. SKILLED NURSING FACILITY PAYMENT UPDATE.

7 (a) IN GENERAL.—Section 1888(e)(4)(E)(ii) of the
8 Social Security Act (42 U.S.C. 1395yy(e)(4)(E)(ii)) is
9 amended—

10 (1) in subclause (III), by striking ''and'' at the
11 end;

12 (2) by redesignating subclause (IV) as sub-
13 clause (VI); and

14 (3) by inserting after subclause (III) the fol-
15 lowing new subclauses:

16 ''(IV) for each of fiscal years
17 2004 through 2009, the rate com-
18 puted for the previous fiscal year in-
19 creased by the skilled nursing facility
20 market basket percentage change for
21 the fiscal year involved;

1 "(V) for fiscal year 2010, the
2 rate computed for the previous fiscal
3 year; and".
4 (b) DELAYED EFFECTIVE DATE.—Section
5 1888(e)(4)(E)(ii)(V) of the Social Security Act, as in-
6 serted by subsection (a)(3), shall not apply to payment
7 for days before January 1, 2010.

8 **SEC. 1102. INPATIENT REHABILITATION FACILITY PAY-**
9 **MENT UPDATE.**

10 (a) IN GENERAL.—Section 1886(j)(3)(C) of the So-
11 cial Security Act (42 U.S.C. 1395ww(j)(3)(C)) is amended
12 by striking "and 2009" and inserting "through 2010".
13 (b) DELAYED EFFECTIVE DATE.—The amendment
14 made by subsection (a) shall not apply to payment units
15 occurring before January 1, 2010.

16 **SEC. 1103. INCORPORATING PRODUCTIVITY IMPROVE-**
17 **MENTS INTO MARKET BASKET UPDATES**
18 **THAT DO NOT ALREADY INCORPORATE SUCH**
19 **IMPROVEMENTS.**

20 (a) INPATIENT ACUTE HOSPITALS.—Section
21 1886(b)(3)(B) of the Social Security Act (42 U.S.C.
22 1395ww(b)(3)(B)) is amended—
23 (1) in clause (iii)—
24 (A) by striking "(iii) For purposes of this
25 subparagraph," and inserting "(iii)(I) For pur-

1 poses of this subparagraph, subject to the pro-
2 ductivity adjustment described in subclause
3 (II),''; and
4 (B) by adding at the end the following new
5 subclause:
6 ''(II) The productivity adjustment described in this
7 subclause, with respect to an increase or change for a fis-
8 cal year or year or cost reporting period, or other annual
9 period, is a productivity offset equal to the percentage
10 change in the 10-year moving average of annual economy-
11 wide private nonfarm business multi-factor productivity
12 (as recently published before the promulgation of such in-
13 crease for the year or period involved). Except as other-
14 wise provided, any reference to the increase described in
15 this clause shall be a reference to the percentage increase
16 described in subclause (I) minus the percentage change
17 under this subclause.'';
18 (2) in the first sentence of clause (viii)(I), by
19 inserting ''(but not below zero)'' after ''shall be re-
20 duced''; and
21 (3) in the first sentence of clause (ix)(I)—
22 (A) by inserting ''(determined without re-
23 gard to clause (iii)(II)'' after ''clause (i)'' the
24 second time it appears; and

1 (B) by inserting ''(but not below zero)''
2 after ''reduced''.
3 (b) SKILLED NURSING FACILITIES.—Section
4 1888(e)(5)(B) of such Act (42 U.S.C. 1395yy(e)(5))(B)
5 is amended by inserting ''subject to the productivity ad-
6 justment described in section 1886(b)(3)(B)(iii)(II)'' after
7 ''as calculated by the Secretary''.
8 (c) LONG TERM CARE HOSPITALS.—Section
9 1886(m) of the Social Security Act (42 U.S.C.
10 1395ww(m)) is amended by adding at the end the fol-
11 lowing new paragraph:
12 ''(3) PRODUCTIVITY ADJUSTMENT.—In imple-
13 menting the system described in paragraph (1) for
14 discharges occurring during the rate year ending in
15 2010 or any subsequent rate year for a hospital, to
16 the extent that an annual percentage increase factor
17 applies to a base rate for such discharges for the
18 hospital, such factor shall be subject to the produc-
19 tivity adjustment described in section
20 1886(b)(3)(B)(iii)(II).''.
21 (d) INPATIENT REHABILITATION FACILITIES.—The
22 second sentence of section 1886(j)(3)(C) of the Social Se-
23 curity Act (42 U.S.C. 1395ww(j)(3)(C)) is amended by in-
24 serting ''(subject to the productivity adjustment described

1 in section 1886(b)(3)(B)(iii)(II))'' after ''appropriate per-
2 centage increase''.
3 (e) PSYCHIATRIC HOSPITALS.—Section 1886 of the
4 Social Security Act (42 U.S.C. 1395ww) is amended by
5 adding at the end the following new subsection:
6 ''(o) PROSPECTIVE PAYMENT FOR PSYCHIATRIC
7 HOSPITALS.—
8 ''(1) REFERENCE TO ESTABLISHMENT AND IM-
9 PLEMENTATION OF SYSTEM.—For provisions related
10 to the establishment and implementation of a pro-
11 spective payment system for payments under this
12 title for inpatient hospital services furnished by psy-
13 chiatric hospitals (as described in clause (i) of sub-
14 section (d)(1)(B) and psychiatric units (as described
15 in the matter following clause (v) of such sub-
16 section), see section 124 of the Medicare, Medicaid,
17 and SCHIP Balanced Budget Refinement Act of
18 1999.
19 ''(2) PRODUCTIVITY ADJUSTMENT.—In imple-
20 menting the system described in paragraph (1) for
21 discharges occurring during the rate year ending in
22 2011 or any subsequent rate year for a psychiatric
23 hospital or unit described in such paragraph, to the
24 extent that an annual percentage increase factor ap-
25 plies to a base rate for such discharges for the hos-

1 pital or unit, respectively, such factor shall be sub-
2 ject to the productivity adjustment described in sec-
3 tion 1886(b)(3)(B)(iii)(II).''.
4 (f) HOSPICE CARE.—Subclause (VII) of section
5 1814(i)(1)(C)(ii) of the Social Security Act (42 U.S.C.
6 1395f(i)(1)(C)(ii)) is amended by inserting after ''the
7 market basket percentage increase'' the following: ''(which
8 is subject to the productivity adjustment described in sec-
9 tion 1886(b)(3)(B)(iii)(II))''.
10 (g) EFFECTIVE DATE.—The amendments made by
11 subsections (a), (b), (d), and (f) shall apply to annual in-
12 creases effected for fiscal years beginning with fiscal year
13 2010.

14 **PART 2—OTHER MEDICARE PART A PROVISIONS**

15 **SEC. 1111. PAYMENTS TO SKILLED NURSING FACILITIES.**

16 (a) CHANGE IN RECALIBRATION FACTOR.—
17 (1) ANALYSIS.—The Secretary of Health and
18 Human Services shall conduct, using calendar year
19 2006 claims data, an initial analysis comparing total
20 payments under title XVIII of the Social Security
21 Act for skilled nursing facility services under the
22 RUG–53 and under the RUG–44 classification sys-
23 tems.
24 (2) ADJUSTMENT IN RECALIBRATION FAC-
25 TOR.—Based on the initial analysis under paragraph

1 (1), the Secretary shall adjust the case mix indexes
2 under section 1888(e)(4)(G)(i) of the Social Security
3 Act (42 U.S.C. 1395yy(e)(4)(G)(i)) for fiscal year
4 2010 by the appropriate recalibration factor as pro-
5 posed in the proposed rule for Medicare skilled nurs-
6 ing facilities issued by such Secretary on May 12,
7 2009 (74 Federal Register 22214 et seq.).

8 (b) CHANGE IN PAYMENT FOR NONTHERAPY ANCIL-
9 LARY (NTA) SERVICES AND THERAPY SERVICES.—

10 (1) CHANGES UNDER CURRENT SNF CLASSI-
11 FICATION SYSTEM.—

12 (A) IN GENERAL.—Subject to subpara-
13 graph (B), the Secretary of Health and Human
14 Services shall, under the system for payment of
15 skilled nursing facility services under section
16 1888(e) of the Social Security Act (42 U.S.C.
17 1395yy(e)), increase payment by 10 percent for
18 non-therapy ancillary services (as specified by
19 the Secretary in the notice issued on November
20 27, 1998 (63 Federal Register 65561 et seq.))
21 and shall decrease payment for the therapy case
22 mix component of such rates by 5.5 percent.

23 (B) EFFECTIVE DATE.—The changes in
24 payment described in subparagraph (A) shall
25 apply for days on or after January 1, 2010,

1 and until the Secretary implements an alter-
2 native case mix classification system for pay-
3 ment of skilled nursing facility services under
4 section 1888(e) of the Social Security Act (42
5 U.S.C. 1395yy(e)).
6 (C) IMPLEMENTATION.—Notwithstanding
7 any other provision of law, the Secretary may
8 implement by program instruction or otherwise
9 the provisions of this paragraph.
10 (2) CHANGES UNDER A FUTURE SNF CASE MIX
11 CLASSIFICATION SYSTEM.—
12 (A) ANALYSIS.—
13 (i) IN GENERAL.—The Secretary of
14 Health and Human Services shall analyze
15 payments for non-therapy ancillary services
16 under a future skilled nursing facility clas-
17 sification system to ensure the accuracy of
18 payment for non-therapy ancillary services.
19 Such analysis shall consider use of appro-
20 priate predictors which may include age,
21 physical and mental status, ability to per-
22 form activities of daily living, prior nursing
23 home stay diagnoses, broad RUG category,
24 and a proxy for length of stay.

1 (ii) APPLICATION.—Such analysis
2 shall be conducted in a manner such that
3 the future skilled nursing facility classifica-
4 tion system is implemented to apply to
5 services furnished during a fiscal year be-
6 ginning with fiscal year 2011.
7 (B) CONSULTATION.—In conducting the
8 analysis under subparagraph (A), the Secretary
9 shall consult with interested parties, including
10 the Medicare Payment Advisory Commission
11 and other interested stakeholders, to identify
12 appropriate predictors of nontherapy ancillary
13 costs.
14 (C) RULEMAKING.—The Secretary shall
15 include the result of the analysis under sub-
16 paragraph (A) in the fiscal year 2011 rule-
17 making cycle for purposes of implementation
18 beginning for such fiscal year.
19 (D) IMPLEMENTATION.—Subject to sub-
20 paragraph (E) and consistent with subpara-
21 graph (A)(ii), the Secretary shall implement
22 changes to payments for non-therapy ancillary
23 services (which shall include a separate rate
24 component for non-therapy ancillary services
25 and may include use of a model that predicts

1 payment amounts applicable for non-therapy
2 ancillary services) under such future skilled
3 nursing facility services classification system as
4 the Secretary determines appropriate based on
5 the analysis conducted pursuant to subpara-
6 graph (A).
7 (E) BUDGET NEUTRALITY.—The Secretary
8 shall implement changes described in subpara-
9 graph (D) in a manner such that the estimated
10 expenditures under such future skilled nursing
11 facility services classification system for a fiscal
12 year beginning with fiscal year 2011 with such
13 changes would be equal to the estimated ex-
14 penditures that would otherwise occur under
15 title XVIII of the Social Security Act under
16 such future skilled nursing facility services clas-
17 sification system for such year without such
18 changes.
19 (c) OUTLIER POLICY FOR NTA AND THERAPY.—Sec-
20 tion 1888(e) of the Social Security Act (42 U.S.C.
21 1395yy(e)) is amended by adding at the end the following
22 new paragraph:
23 ‘‘(13) OUTLIERS FOR NTA AND THERAPY.—
24 ‘‘(A) IN GENERAL.—With respect to
25 outliers because of unusual variations in the

1 type or amount of medically necessary care, be-
2 ginning with October 1, 2010, the Secretary—
3 ‘‘(i) shall provide for an addition or
4 adjustment to the payment amount other-
5 wise made under this section with respect
6 to non-therapy ancillary services in the
7 case of such outliers; and
8 ‘‘(ii) may provide for such an addition
9 or adjustment to the payment amount oth-
10 erwise made under this section with re-
11 spect to therapy services in the case of
12 such outliers.
13 ‘‘(B) OUTLIERS BASED ON AGGREGATE
14 COSTS.—Outlier adjustments or additional pay-
15 ments described in subparagraph (A) shall be
16 based on aggregate costs during a stay in a
17 skilled nursing facility and not on the number
18 of days in such stay.
19 ‘‘(C) BUDGET NEUTRALITY.— The Sec-
20 retary shall reduce estimated payments that
21 would otherwise be made under the prospective
22 payment system under this subsection with re-
23 spect to a fiscal year by 2 percent. The total
24 amount of the additional payments or payment
25 adjustments for outliers made under this para-

1 graph with respect to a fiscal year may not ex-
2 ceed 2 percent of the total payments projected
3 or estimated to be made based on the prospec-
4 tive payment system under this subsection for
5 the fiscal year.''.
6 (d) CONFORMING AMENDMENTS.—Section
7 1888(e)(8) of such Act (42 U.S.C. 1395yy(e)(8)) is
8 amended—
9 (1) in subparagraph (A), by inserting ''and ad-
10 justment under section 1111(b) of the America's Af-
11 fordable Health Choices Act of 2009;
12 (2) in subparagraph (B), by striking ''and'';
13 (3) in subparagraph (C), by striking the period
14 and inserting ''; and''; and
15 (4) by adding at the end the following new sub-
16 paragraph:
17 ''(D) the establishment of outliers under
18 paragraph (13).''.
19 **SEC. 1112. MEDICARE DSH REPORT AND PAYMENT ADJUST-**
20 **MENTS IN RESPONSE TO COVERAGE EXPAN-**
21 **SION.**
22 (a) DSH REPORT.—
23 (1) IN GENERAL.—Not later than January 1,
24 2016, the Secretary of Health and Human Services
25 shall submit to Congress a report on Medicare DSH

1 taking into account the impact of the health care re-
2 forms carried out under division A in reducing the
3 number of uninsured individuals. The report shall
4 include recommendations relating to the following:
5 (A) The appropriate amount, targeting,
6 and distribution of Medicare DSH to com-
7 pensate for higher Medicare costs associated
8 with serving low-income beneficiaries (taking
9 into account variations in the empirical jus-
10 tification for Medicare DSH attributable to hos-
11 pital characteristics, including bed size), con-
12 sistent with the original intent of Medicare
13 DSH.
14 (B) The appropriate amount, targeting,
15 and distribution of Medicare DSH to hospitals
16 given their continued uncompensated care costs,
17 to the extent such costs remain.
18 (2) COORDINATION WITH MEDICAID DSH RE-
19 PORT.—The Secretary shall coordinate the report
20 under this subsection with the report on Medicaid
21 DSH under section 1704(a).
22 (b) PAYMENT ADJUSTMENTS IN RESPONSE TO COV-
23 ERAGE EXPANSION.—
24 (1) IN GENERAL.—If there is a significant de-
25 crease in the national rate of uninsurance as a result

1 of this Act (as determined under paragraph (2)(A)),
2 then the Secretary of Health and Human Services
3 shall, beginning in fiscal year 2017, implement the
4 following adjustments to Medicare DSH:

5 (A) In lieu of the amount of Medicare
6 DSH payment that would otherwise be made
7 under section 1886(d)(5)(F) of the Social Secu-
8 rity Act, the amount of Medicare DSH payment
9 shall be an amount based on the recommenda-
10 tions of the report under subsection (a)(1)(A)
11 and shall take into account variations in the
12 empirical justification for Medicare DSH attrib-
13 utable to hospital characteristics, including bed
14 size.

15 (B) Subject to paragraph (3), make an ad-
16 ditional payment to a hospital by an amount
17 that is estimated based on the amount of un-
18 compensated care provided by the hospital
19 based on criteria for uncompensated care as de-
20 termined by the Secretary, which shall exclude
21 bad debt.

22 (2) SIGNIFICANT DECREASE IN NATIONAL RATE
23 OF UNINSURANCE AS A RESULT OF THIS ACT.—For
24 purposes of this subsection—

1 (A) IN GENERAL.—There is a ''significant
2 decrease in the national rate of uninsurance as
3 a result of this Act'' if there is a decrease in
4 the national rate of uninsurance (as defined in
5 subparagraph (B)) from 2012 to 2014 that ex-
6 ceeds 8 percentage points.
7 (B) NATIONAL RATE OF UNINSURANCE
8 DEFINED.—The term ''national rate of
9 uninsurance'' means, for a year, such rate for
10 the under-65 population for the year as deter-
11 mined and published by the Bureau of the Cen-
12 sus in its Current Population Survey in or
13 about September of the succeeding year.
14 (3) UNCOMPENSATED CARE INCREASE.—
15 (A) COMPUTATION OF DSH SAVINGS.—For
16 each fiscal year (beginning with fiscal year
17 2017), the Secretary shall estimate the aggre-
18 gate reduction in the amount of Medicare DSH
19 payment that would be expected to result from
20 the adjustment under paragraph (1)(A).
21 (B) STRUCTURE OF PAYMENT IN-
22 CREASE.—The Secretary shall compute the ad-
23 ditional payment to a hospital as described in
24 paragraph (1)(B) for a fiscal year in accordance

1 with a formula established by the Secretary
2 that provides that—
3 (i) the estimated aggregate amount of
4 such increase for the fiscal year does not
5 exceed 50 percent of the aggregate reduc-
6 tion in Medicare DSH estimated by the
7 Secretary for such fiscal year; and
8 (ii) hospitals with higher levels of un-
9 compensated care receive a greater in-
10 crease.
11 (c) MEDICARE DSH.—In this section, the term
12 ''Medicare DSH'' means adjustments in payments under
13 section 1886(d)(5)(F) of the Social Security Act (42
14 U.S.C. 1395ww(d)(5)(F)) for inpatient hospital services
15 furnished by disproportionate share hospitals.

16 **SEC. 1113. EXTENSION OF HOSPICE REGULATION MORATO-**
17 **RIUM.**

18 Section 4301(a) of division B of the American Recov-
19 ery and Reinvestment Act of 2009 (Public Law 111–5)
20 is amended—
21 (1) by striking ''October 1, 2009'' and inserting
22 ''October 1, 2010''; and
23 (2) by striking ''for fiscal year 2009'' and in-
24 serting ''for fiscal years 2009 and 2010''.

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—

1 "(i) the allowed expenditures for 2009
2 shall be equal to the amount of the actual
3 expenditures for physicians' services during
4 2009; and
5 "(ii) the reference in subparagraph
6 (B)(ii)(I) to 'April 1, 1996' shall be treat-
7 ed as a reference to 'January 1, 2009 (or,
8 if later, the first day of the fifth year be-
9 fore the year involved)'.".
10 (c) LIMITATION ON PHYSICIANS' SERVICES IN-
11 CLUDED IN TARGET GROWTH RATE COMPUTATION TO
12 SERVICES COVERED UNDER PHYSICIAN FEE SCHED-
13 ULE.—Effective for services furnished on or after January
14 1, 2009, section 1848(f)(4)(A) of such Act is amended
15 striking "(such as clinical" and all that follows through
16 "in a physician's office" and inserting "for which payment
17 under this part is made under the fee schedule under this
18 section, for services for practitioners described in section
19 1842(b)(18)(C) on a basis related to such fee schedule,
20 or for services described in section 1861(p) (other than
21 such services when furnished in the facility of a provider
22 of services)".
23 (d) ESTABLISHMENT OF SEPARATE TARGET
24 GROWTH RATES FOR CATEGORIES OF SERVICES.—

1 (1) ESTABLISHMENT OF SERVICE CAT-
2 EGORIES.—Subsection (j) of section 1848 of the So-
3 cial Security Act (42 U.S.C. 1395w–4) is amended
4 by adding at the end the following new paragraph:
5 ''(5) SERVICE CATEGORIES.—For services fur-
6 nished on or after January 1, 2009, each of the fol-
7 lowing categories of physicians' services (as defined
8 in paragraph (3)) shall be treated as a separate
9 'service category':
10 ''(A) Evaluation and management services
11 that are procedure codes (for services covered
12 under this title) for—
13 ''(i) services in the category des-
14 ignated Evaluation and Management in the
15 Health Care Common Procedure Coding
16 System (established by the Secretary under
17 subsection (c)(5) as of December 31, 2009,
18 and as subsequently modified by the Sec-
19 retary); and
20 ''(ii) preventive services (as defined in
21 section 1861(iii)) for which payment is
22 made under this section.
23 ''(B) All other services not described in
24 subparagraph (A).

1 Service categories established under this paragraph
2 shall apply without regard to the specialty of the
3 physician furnishing the service.''.
4 (2) ESTABLISHMENT OF SEPARATE CONVER-
5 SION FACTORS FOR EACH SERVICE CATEGORY.—
6 Subsection (d)(1) of section 1848 of the Social Secu-
7 rity Act (42 U.S.C. 1395w–4) is amended—
8 (A) in subparagraph (A)—
9 (i) by designating the sentence begin-
10 ning ''The conversion factor'' as clause (i)
11 with the heading ''APPLICATION OF SIN-
12 GLE CONVERSION FACTOR.—'' and with
13 appropriate indentation;
14 (ii) by striking ''The conversion fac-
15 tor'' and inserting ''Subject to clause (ii),
16 the conversion factor''; and
17 (iii) by adding at the end the fol-
18 lowing new clause:
19 ''(ii) APPLICATION OF MULTIPLE CON-
20 VERSION FACTORS BEGINNING WITH
21 2011.—
22 ''(I) IN GENERAL.—In applying
23 clause (i) for years beginning with
24 2011, separate conversion factors
25 shall be established for each service

1 category of physicians' services (as de-
2 fined in subsection (j)(5)) and any
3 reference in this section to a conver-
4 sion factor for such years shall be
5 deemed to be a reference to the con-
6 version factor for each of such cat-
7 egories.

8 "(II) INITIAL CONVERSION FAC-
9 TORS.—Such factors for 2011 shall be
10 based upon the single conversion fac-
11 tor for the previous year multiplied by
12 the update established under para-
13 graph (11) for such category for
14 2011.

15 "(III) UPDATING OF CONVER-
16 SION FACTORS.—Such factor for a
17 service category for a subsequent year
18 shall be based upon the conversion
19 factor for such category for the pre-
20 vious year and adjusted by the update
21 established for such category under
22 paragraph (11) for the year in-
23 volved."; and

24 (B) in subparagraph (D), by striking
25 "other physicians' services" and inserting "for

1 physicians' services described in the service cat-
2 egory described in subsection (j)(5)(B)''.
3 (3) ESTABLISHING UPDATES FOR CONVERSION
4 FACTORS FOR SERVICE CATEGORIES.—Section
5 1848(d) of the Social Security Act (42 U.S.C.
6 1395w–4(d)), as amended by subsection (a), is
7 amended—
8 (A) in paragraph (4)(C)(iii), by striking
9 ''The allowed'' and inserting ''Subject to para-
10 graph (11)(B), the allowed''; and
11 (B) by adding at the end the following new
12 paragraph:
13 ''(11) UPDATES FOR SERVICE CATEGORIES BE-
14 GINNING WITH 2011.—
15 ''(A) IN GENERAL.—In applying paragraph
16 (4) for a year beginning with 2011, the fol-
17 lowing rules apply:
18 ''(i) APPLICATION OF SEPARATE UP-
19 DATE ADJUSTMENTS FOR EACH SERVICE
20 CATEGORY.—Pursuant to paragraph
21 (1)(A)(ii)(I), the update shall be made to
22 the conversion factor for each service cat-
23 egory (as defined in subsection (j)(5))
24 based upon an update adjustment factor
25 for the respective category and year and

1 the update adjustment factor shall be com-
2 puted, for a year, separately for each serv-
3 ice category.
4 "(ii) COMPUTATION OF ALLOWED AND
5 ACTUAL EXPENDITURES BASED ON SERV-
6 ICE CATEGORIES.—In computing the prior
7 year adjustment component and the cumu-
8 lative adjustment component under clauses
9 (i) and (ii) of paragraph (4)(B), the fol-
10 lowing rules apply:
11 "(I) APPLICATION BASED ON
12 SERVICE CATEGORIES.—The allowed
13 expenditures and actual expenditures
14 shall be the allowed and actual ex-
15 penditures for the service category, as
16 determined under subparagraph (B).
17 "(II) APPLICATION OF CATEGORY
18 SPECIFIC TARGET GROWTH RATE.—
19 The growth rate applied under clause
20 (ii)(II) of such paragraph shall be the
21 target growth rate for the service cat-
22 egory involved under subsection (f)(5).
23 "(B) DETERMINATION OF ALLOWED EX-
24 PENDITURES.—In applying paragraph (4) for a
25 year beginning with 2010, notwithstanding sub-

1 paragraph (C)(iii) of such paragraph, the al-
2 lowed expenditures for a service category for a
3 year is an amount computed by the Secretary
4 as follows:
5 "(i) FOR 2010.—For 2010:
6 "(I) TOTAL 2009 ACTUAL EX-
7 PENDITURES FOR ALL SERVICES IN-
8 CLUDED IN SGR COMPUTATION FOR
9 EACH SERVICE CATEGORY.—Compute
10 total actual expenditures for physi-
11 cians' services (as defined in sub-
12 section (f)(4)(A)) for 2009 for each
13 service category.
14 "(II) INCREASE BY GROWTH
15 RATE TO OBTAIN 2010 ALLOWED EX-
16 PENDITURES FOR SERVICE CAT-
17 EGORY.—Compute allowed expendi-
18 tures for the service category for 2010
19 by increasing the allowed expenditures
20 for the service category for 2009 com-
21 puted under subclause (I) by the tar-
22 get growth rate for such service cat-
23 egory under subsection (f) for 2010.
24 "(ii) FOR SUBSEQUENT YEARS.—For
25 a subsequent year, take the amount of al-

1 lowed expenditures for such category for
2 the preceding year (under clause (i) or this
3 clause) and increase it by the target
4 growth rate determined under subsection
5 (f) for such category and year.''.
6 (4) APPLICATION OF SEPARATE TARGET
7 GROWTH RATES FOR EACH CATEGORY.—
8 (A) IN GENERAL.—Section 1848(f) of the
9 Social Security Act (42 U.S.C. 1395w–4(f)) is
10 amended by adding at the end the following
11 new paragraph:
12 ''(5) APPLICATION OF SEPARATE TARGET
13 GROWTH RATES FOR EACH SERVICE CATEGORY BE-
14 GINNING WITH 2010.—The target growth rate for a
15 year beginning with 2010 shall be computed and ap-
16 plied separately under this subsection for each serv-
17 ice category (as defined in subsection (j)(5)) and
18 shall be computed using the same method for com-
19 puting the target growth rate except that the factor
20 described in paragraph (2)(C) for—
21 ''(A) the service category described in sub-
22 section (j)(5)(A) shall be increased by 0.02; and
23 ''(B) the service category described in sub-
24 section (j)(5)(B) shall be increased by 0.01.''.

1 (B) USE OF TARGET GROWTH RATES.—
2 Section 1848 of such Act is further amended—
3 (i) in subsection (d)—
4 (I) in paragraph (1)(E)(ii), by in-
5 serting ''or target'' after ''sustain-
6 able''; and
7 (II) in paragraph (4)(B)(ii)(II),
8 by inserting ''or target'' after ''sus-
9 tainable''; and
10 (ii) in the heading of subsection (f),
11 by inserting ''AND TARGET GROWTH
12 RATE'' after ''SUSTAINABLE GROWTH
13 RATE'';
14 (iii) in subsection (f)(1)—
15 (I) by striking ''and'' at the end
16 of subparagraph (A);
17 (II) in subparagraph (B), by in-
18 serting ''before 2010'' after ''each
19 succeeding year'' and by striking the
20 period at the end and inserting '';
21 and''; and
22 (III) by adding at the end the
23 following new subparagraph:

1 "(C) November 1 of each succeeding year
2 the target growth rate for such succeeding year
3 and each of the 2 preceding years."; and
4 (iv) in subsection (f)(2), in the matter
5 before subparagraph (A), by inserting after
6 "beginning with 2000" the following: "and
7 ending with 2009".
8 (e) APPLICATION TO ACCOUNTABLE CARE ORGANI-
9 ZATION PILOT PROGRAM.—In applying the target growth
10 rate under subsections (d) and (f) of section 1848 of the
11 Social Security Act to services furnished by a practitioner
12 to beneficiaries who are attributable to an accountable
13 care organization under the pilot program provided under
14 section 1866D of such Act, the Secretary of Health and
15 Human Services shall develop, not later than January 1,
16 2012, for application beginning with 2012, a method
17 that—
18 (1) allows each such organization to have its
19 own expenditure targets and updates for such practi-
20 tioners, with respect to beneficiaries who are attrib-
21 utable to that organization, that are consistent with
22 the methodologies described in such subsection (f);
23 and
24 (2) provides that the target growth rate appli-
25 cable to other physicians shall not apply to such

1 physicians to the extent that the physicians' services
2 are furnished through the accountable care organiza-
3 tion.
4 In applying paragraph (1), the Secretary of Health and
5 Human Services may apply the difference in the update
6 under such paragraph on a claim-by-claim or lump sum
7 basis and such a payment shall be taken into account
8 under the pilot program.

9 **SEC. 1122. MISVALUED CODES UNDER THE PHYSICIAN FEE**
10 **SCHEDULE.**

11 (a) IN GENERAL.—Section 1848(c)(2) of the Social
12 Security Act (42 U.S.C. 1395w-4(c)(2)) is amended by
13 adding at the end the following new subparagraphs:
14 "(K) POTENTIALLY MISVALUED CODES.—
15 "(i) IN GENERAL.—The Secretary
16 shall—
17 "(I) periodically identify services
18 as being potentially misvalued using
19 criteria specified in clause (ii); and
20 "(II) review and make appro-
21 priate adjustments to the relative val-
22 ues established under this paragraph
23 for services identified as being poten-
24 tially misvalued under subclause (I).

1 "(ii) IDENTIFICATION OF POTEN-
2 TIALLY MISVALUED CODES.—For purposes
3 of identifying potentially misvalued services
4 pursuant to clause (i)(I), the Secretary
5 shall examine (as the Secretary determines
6 to be appropriate) codes (and families of
7 codes as appropriate) for which there has
8 been the fastest growth; codes (and fami-
9 lies of codes as appropriate) that have ex-
10 perienced substantial changes in practice
11 expenses; codes for new technologies or
12 services within an appropriate period (such
13 as three years) after the relative values are
14 initially established for such codes; mul-
15 tiple codes that are frequently billed in
16 conjunction with furnishing a single serv-
17 ice; codes with low relative values, particu-
18 larly those that are often billed multiple
19 times for a single treatment; codes which
20 have not been subject to review since the
21 implementation of the RBRVS (the so-
22 called 'Harvard-valued codes'); and such
23 other codes determined to be appropriate
24 by the Secretary.
25 "(iii) REVIEW AND ADJUSTMENTS.—

1 "(I) The Secretary may use ex-
2 isting processes to receive rec-
3 ommendations on the review and ap-
4 propriate adjustment of potentially
5 misvalued services described clause
6 (i)(II).
7 "(II) The Secretary may conduct
8 surveys, other data collection activi-
9 ties, studies, or other analyses as the
10 Secretary determines to be appro-
11 priate to facilitate the review and ap-
12 propriate adjustment described in
13 clause (i)(II).
14 "(III) The Secretary may use
15 analytic contractors to identify and
16 analyze services identified under
17 clause (i)(I), conduct surveys or col-
18 lect data, and make recommendations
19 on the review and appropriate adjust-
20 ment of services described in clause
21 (i)(II).
22 "(IV) The Secretary may coordi-
23 nate the review and appropriate ad-
24 justment described in clause (i)(II)

1 with the periodic review described in
2 subparagraph (B).
3 "(V) As part of the review and
4 adjustment described in clause (i)(II),
5 including with respect to codes with
6 low relative values described in clause
7 (ii), the Secretary may make appro-
8 priate coding revisions (including
9 using existing processes for consider-
10 ation of coding changes) which may
11 include consolidation of individual
12 services into bundled codes for pay-
13 ment under the fee schedule under
14 subsection (b).
15 "(VI) The provisions of subpara-
16 graph (B)(ii)(II) shall apply to adjust-
17 ments to relative value units made
18 pursuant to this subparagraph in the
19 same manner as such provisions apply
20 to adjustments under subparagraph
21 (B)(ii)(II).
22 "(L) VALIDATING RELATIVE VALUE
23 UNITS.—
24 "(i) IN GENERAL.—The Secretary
25 shall establish a process to validate relative

1 value units under the fee schedule under
2 subsection (b).
3 ‘‘(ii) COMPONENTS AND ELEMENTS
4 OF WORK.—The process described in
5 clause (i) may include validation of work
6 elements (such as time, mental effort and
7 professional judgment, technical skill and
8 physical effort, and stress due to risk) in-
9 volved with furnishing a service and may
10 include validation of the pre, post, and
11 intra-service components of work.
12 ‘‘(iii) SCOPE OF CODES.—The valida-
13 tion of work relative value units shall in-
14 clude a sampling of codes for services that
15 is the same as the codes listed under sub-
16 paragraph (K)(ii)
17 ‘‘(iv) METHODS.—The Secretary may
18 conduct the validation under this subpara-
19 graph using methods described in sub-
20 clauses (I) through (V) of subparagraph
21 (K)(iii) as the Secretary determines to be
22 appropriate.
23 ‘‘(v) ADJUSTMENTS.—The Secretary
24 shall make appropriate adjustments to the
25 work relative value units under the fee

1 schedule under subsection (b). The provi-
2 sions of subparagraph (B)(ii)(II) shall
3 apply to adjustments to relative value units
4 made pursuant to this subparagraph in the
5 same manner as such provisions apply to
6 adjustments under subparagraph
7 (B)(ii)(II).''.
8 (b) IMPLEMENTATION.—
9 (1) FUNDING.—For purposes of carrying out
10 the provisions of subparagraphs (K) and (L) of
11 1848(c)(2) of the Social Security Act, as added by
12 subsection (a), in addition to funds otherwise avail-
13 able, out of any funds in the Treasury not otherwise
14 appropriated, there are appropriated to the Sec-
15 retary of Health and Human Services for the Center
16 for Medicare & Medicaid Services Program Manage-
17 ment Account $20,000,000 for fiscal year 2010 and
18 each subsequent fiscal year. Amounts appropriated
19 under this paragraph for a fiscal year shall be avail-
20 able until expended.
21 (2) ADMINISTRATION.—
22 (A) Chapter 35 of title 44, United States
23 Code and the provisions of the Federal Advisory
24 Committee Act (5 U.S.C. App.) shall not apply

1 to this section or the amendment made by this
2 section.
3 (B) Notwithstanding any other provision of
4 law, the Secretary may implement subpara-
5 graphs (K) and (L) of 1848(c)(2) of the Social
6 Security Act, as added by subsection (a), by
7 program instruction or otherwise.
8 (C) Section 4505(d) of the Balanced
9 Budget Act of 1997 is repealed.
10 (D) Except for provisions related to con-
11 fidentiality of information, the provisions of the
12 Federal Acquisition Regulation shall not apply
13 to this section or the amendment made by this
14 section.
15 (3) FOCUSING CMS RESOURCES ON POTEN-
16 TIALLY OVERVALUED CODES.—Section 1868(a) of
17 the Social Security Act (42 1395ee(a)) is repealed.
18 **SEC. 1123. PAYMENTS FOR EFFICIENT AREAS.**
19 Section 1833 of the Social Security Act (42 U.S.C.
20 1395l) is amended by adding at the end the following new
21 subsection:
22 "(x) INCENTIVE PAYMENTS FOR EFFICIENT
23 AREAS.—
24 "(1) IN GENERAL.—In the case of services fur-
25 nished under the physician fee schedule under sec-

1 tion 1848 on or after January 1, 2011, and before
2 January 1, 2013, by a supplier that is paid under
3 such fee schedule in an efficient area (as identified
4 under paragraph (2)), in addition to the amount of
5 payment that would otherwise be made for such
6 services under this part, there also shall be paid (on
7 a monthly or quarterly basis) an amount equal to 5
8 percent of the payment amount for the services
9 under this part.

10 ''(2) IDENTIFICATION OF EFFICIENT AREAS.—

11 ''(A) IN GENERAL.—Based upon available
12 data, the Secretary shall identify those counties
13 or equivalent areas in the United States in the
14 lowest fifth percentile of utilization based on
15 per capita spending under this part and part A
16 for services provided in the most recent year for
17 which data are available as of the date of the
18 enactment of this subsection, as standardized to
19 eliminate the effect of geographic adjustments
20 in payment rates.

21 ''(B) IDENTIFICATION OF COUNTIES
22 WHERE SERVICE IS FURNISHED..—For pur-
23 poses of paying the additional amount specified
24 in paragraph (1), if the Secretary uses the 5-
25 digit postal ZIP Code where the service is fur-

1 nished, the dominant county of the postal ZIP
2 Code (as determined by the United States Post-
3 al Service, or otherwise) shall be used to deter-
4 mine whether the postal ZIP Code is in a coun-
5 ty described in subparagraph (A).

6 ''(C) LIMITATION ON REVIEW.—There
7 shall be no administrative or judicial review
8 under section 1869, 1878, or otherwise, respect-
9 ing—

10 ''(i) the identification of a county or
11 other area under subparagraph (A); or

12 ''(ii) the assignment of a postal ZIP
13 Code to a county or other area under sub-
14 paragraph (B).

15 ''(D) PUBLICATION OF LIST OF COUNTIES;
16 POSTING ON WEBSITE.—With respect to a year
17 for which a county or area is identified under
18 this paragraph, the Secretary shall identify
19 such counties or areas as part of the proposed
20 and final rule to implement the physician fee
21 schedule under section 1848 for the applicable
22 year. The Secretary shall post the list of coun-
23 ties identified under this paragraph on the
24 Internet website of the Centers for Medicare &
25 Medicaid Services.''.

1 **SEC. 1124. MODIFICATIONS TO THE PHYSICIAN QUALITY**
2 **REPORTING INITIATIVE (PQRI).**

3 (a) FEEDBACK.—Section 1848(m)(5) of the Social
4 Security Act (42 U.S.C. 1395w–4(m)(5)) is amended by
5 adding at the end the following new subparagraph:

6 "(H) FEEDBACK.—The Secretary shall
7 provide timely feedback to eligible professionals
8 on the performance of the eligible professional
9 with respect to satisfactorily submitting data on
10 quality measures under this subsection.".

11 (b) APPEALS.—Such section is further amended—

12 (1) in subparagraph (E), by striking "There
13 shall be" and inserting "Subject to subparagraph
14 (I), there shall be"; and

15 (2) by adding at the end the following new sub-
16 paragraph:

17 "(I) INFORMAL APPEALS PROCESS.—Not-
18 withstanding subparagraph (E), by not later
19 than January 1, 2011, the Secretary shall es-
20 tablish and have in place an informal process
21 for eligible professionals to appeal the deter-
22 mination that an eligible professional did not
23 satisfactorily submit data on quality measures
24 under this subsection.".

25 (c) INTEGRATION OF PHYSICIAN QUALITY REPORT-
26 ING AND EHR REPORTING.—Section 1848(m) of such

1 Act is amended by adding at the end the following new
2 paragraph:
3 "(7) INTEGRATION OF PHYSICIAN QUALITY RE-
4 PORTING AND EHR REPORTING.—Not later than
5 January 1, 2012, the Secretary shall develop a plan
6 to integrate clinical reporting on quality measures
7 under this subsection with reporting requirements
8 under subsection (o) relating to the meaningful use
9 of electronic health records. Such integration shall
10 consist of the following:
11 "(A) The development of measures, the re-
12 porting of which would both demonstrate—
13 "(i) meaningful use of an electronic
14 health record for purposes of subsection
15 (o); and
16 "(ii) clinical quality of care furnished
17 to an individual.
18 "(B) The collection of health data to iden-
19 tify deficiencies in the quality and coordination
20 of care for individuals eligible for benefits under
21 this part.
22 "(C) Such other activities as specified by
23 the Secretary.".

1 (d) EXTENSION OF INCENTIVE PAYMENTS.—Section
2 1848(m)(1) of such Act (42 U.S.C. 1395w–4(m)(1)) is
3 amended—
4 (1) in subparagraph (A), by striking ''2010''
5 and inserting ''2012''; and
6 (2) in subparagraph (B)(ii), by striking ''2009
7 and 2010'' and inserting ''for each of the years 2009
8 through 2012''.

9 **SEC. 1125. ADJUSTMENT TO MEDICARE PAYMENT LOCAL-**
10 **ITIES.**

11 (a) IN GENERAL.—Section 1848(e) of the Social Se-
12 curity Act (42 U.S.C.1395w–4(e)) is amended by adding
13 at the end the following new paragraph:
14 ''(6) TRANSITION TO USE OF MSAS AS FEE
15 SCHEDULE AREAS IN CALIFORNIA.—
16 ''(A) IN GENERAL.—
17 ''(i) REVISION.—Subject to clause (ii)
18 and notwithstanding the previous provi-
19 sions of this subsection, for services fur-
20 nished on or after January 1, 2011, the
21 Secretary shall revise the fee schedule
22 areas used for payment under this section
23 applicable to the State of California using
24 the Metropolitan Statistical Area (MSA)

1 iterative Geographic Adjustment Factor
2 methodology as follows:
3 "(I) The Secretary shall con-
4 figure the physician fee schedule areas
5 using the Core-Based Statistical
6 Areas-Metropolitan Statistical Areas
7 (each in this paragraph referred to as
8 an 'MSA'), as defined by the Director
9 of the Office of Management and
10 Budget, as the basis for the fee sched-
11 ule areas. The Secretary shall employ
12 an iterative process to transition fee
13 schedule areas. First, the Secretary
14 shall list all MSAs within the State by
15 Geographic Adjustment Factor de-
16 scribed in paragraph (2) (in this para-
17 graph referred to as a 'GAF') in de-
18 scending order. In the first iteration,
19 the Secretary shall compare the GAF
20 of the highest cost MSA in the State
21 to the weighted-average GAF of the
22 group of remaining MSAs in the
23 State. If the ratio of the GAF of the
24 highest cost MSA to the weighted-av-
25 erage GAF of the rest of State is 1.05

1 or greater then the highest cost MSA
2 becomes a separate fee schedule area.
3 "(II) In the next iteration, the
4 Secretary shall compare the MSA of
5 the second-highest GAF to the weight-
6 ed-average GAF of the group of re-
7 maining MSAs. If the ratio of the sec-
8 ond-highest MSA's GAF to the
9 weighted-average of the remaining
10 lower cost MSAs is 1.05 or greater,
11 the second-highest MSA becomes a
12 separate fee schedule area. The
13 iterative process continues until the
14 ratio of the GAF of the highest-cost
15 remaining MSA to the weighted-aver-
16 age of the remaining lower-cost MSAs
17 is less than 1.05, and the remaining
18 group of lower cost MSAs form a sin-
19 gle fee schedule area, If two MSAs
20 have identical GAFs, they shall be
21 combined in the iterative comparison.
22 "(ii) TRANSITION.—For services fur-
23 nished on or after January 1, 2011, and
24 before January 1, 2016, in the State of
25 California, after calculating the work, prac-

1 tice expense, and malpractice geographic
2 indices described in clauses (i), (ii), and
3 (iii) of paragraph (1)(A) that would other-
4 wise apply through application of this
5 paragraph, the Secretary shall increase any
6 such index to the county-based fee sched-
7 ule area value on December 31, 2009, if
8 such index would otherwise be less than
9 the value on January 1, 2010.
10 "(B) SUBSEQUENT REVISIONS.—
11 "(i) PERIODIC REVIEW AND ADJUST-
12 MENTS IN FEE SCHEDULE AREAS.—Subse-
13 quent to the process outlined in paragraph
14 (1)(C), not less often than every three
15 years, the Secretary shall review and up-
16 date the California Rest-of-State fee sched-
17 ule area using MSAs as defined by the Di-
18 rector of the Office of Management and
19 Budget and the iterative methodology de-
20 scribed in subparagraph (A)(i).
21 "(ii) LINK WITH GEOGRAPHIC INDEX
22 DATA REVISION.—The revision described in
23 clause (i) shall be made effective concur-
24 rently with the application of the periodic
25 review of the adjustment factors required

1 under paragraph (1)(C) for California for
2 2012 and subsequent periods. Upon re-
3 quest, the Secretary shall make available
4 to the public any county-level or MSA de-
5 rived data used to calculate the geographic
6 practice cost index.

7 "(C) REFERENCES TO FEE SCHEDULE
8 AREAS.—Effective for services furnished on or
9 after January 1, 2010, for the State of Cali-
10 fornia, any reference in this section to a fee
11 schedule area shall be deemed a reference to an
12 MSA in the State.".

13 (b) CONFORMING AMENDMENT TO DEFINITION OF
14 FEE SCHEDULE AREA.—Section 1848(j)(2) of the Social
15 Security Act (42 U.S.C. 1395w(j)(2)) is amended by strik-
16 ing "The term" and inserting "Except as provided in sub-
17 section (e)(6)(C), the term".

18 **PART 2—MARKET BASKET UPDATES**

19 **SEC. 1131. INCORPORATING PRODUCTIVITY IMPROVE-**
20 **MENTS INTO MARKET BASKET UPDATES**
21 **THAT DO NOT ALREADY INCORPORATE SUCH**
22 **IMPROVEMENTS.**

23 (a) OUTPATIENT HOSPITALS.—

1 (1) IN GENERAL.—The first sentence of section
2 1833(t)(3)(C)(iv) of the Social Security Act (42
3 U.S.C. 1395l(t)(3)(C)(iv)) is amended—
4 (A) by inserting ''(which is subject to the
5 productivity adjustment described in subclause
6 (II) of such section)'' after
7 ''1886(b)(3)(B)(iii)''; and
8 (B) by inserting ''(but not below 0)'' after
9 ''reduced''.
10 (2) EFFECTIVE DATE.—The amendments made
11 by paragraph (1) shall apply to increase factors for
12 services furnished in years beginning with 2010.
13 (b) AMBULANCE SERVICES.—Section 1834(l)(3)(B)
14 of such Act (42 U.S.C. 1395m(l)(3)(B))) is amended by
15 inserting before the period at the end the following: ''and,
16 in the case of years beginning with 2010, subject to the
17 productivity adjustment described in section
18 1886(b)(3)(B)(iii)(II)''.
19 (c) AMBULATORY SURGICAL CENTER SERVICES.—
20 Section 1833(i)(2)(D) of such Act (42 U.S.C.
21 1395l(i)(2)(D)) is amended—
22 (1) by redesignating clause (v) as clause (vi);
23 and
24 (2) by inserting after clause (iv) the following
25 new clause:

1 "(v) In implementing the system described in clause
2 (i), for services furnished during 2010 or any subsequent
3 year, to the extent that an annual percentage change fac-
4 tor applies, such factor shall be subject to the productivity
5 adjustment described in section 1886(b)(3)(B)(iii)(II).".
6 (d) LABORATORY SERVICES.—Section
7 1833(h)(2)(A)) of such Act (42 U.S.C. 1395l(h)(2)(A)) is
8 amended—
9 (1) in clause (i), by striking "for each of years
10 2009 through 2013" and inserting "for 2009"; and
11 (2) clause (ii)—
12 (A) by striking "and" at the end of sub-
13 clause (III);
14 (B) by striking the period at the end of
15 subclause (IV) and inserting "; and"; and
16 (C) by adding at the end the following new
17 subclause:
18 "(V) the annual adjustment in the fee schedules
19 determined under clause (i) for years beginning with
20 2010 shall be subject to the productivity adjustment
21 described in section 1886(b)(3)(B)(iii)(II).".
22 (e) CERTAIN DURABLE MEDICAL EQUIPMENT.—Sec-
23 tion 1834(a)(14) of such Act (42 U.S.C. 1395m(a)(14))
24 is amended—

1 (1) in subparagraph (K), by inserting before
2 the semicolon at the end the following: '', subject to
3 the productivity adjustment described in section
4 1886(b)(3)(B)(iii)(II)'';
5 (2) in subparagraph (L)(i), by inserting after
6 ''June 2013,'' the following: ''subject to the produc-
7 tivity adjustment described in section
8 1886(b)(3)(B)(iii)(II),'';
9 (3) in subparagraph (L)(ii), by inserting after
10 ''June 2013'' the following: '', subject to the produc-
11 tivity adjustment described in section
12 1886(b)(3)(B)(iii)(II)''; and
13 (4) in subparagraph (M), by inserting before
14 the period at the end the following: '', subject to the
15 productivity adjustment described in section
16 1886(b)(3)(B)(iii)(II)''.

17 **PART 3—OTHER PROVISIONS**

18 **SEC. 1141. RENTAL AND PURCHASE OF POWER-DRIVEN**
19 **WHEELCHAIRS.**

20 (a) IN GENERAL.—Section 1834(a)(7)(A)(iii) of the
21 Social Security Act (42 U.S.C. 1395m(a)(7)(A)(iii)) is
22 amended—
23 (1) in the heading, by inserting ''CERTAIN COM-
24 PLEX REHABILITATIVE'' after ''OPTION FOR''; and

1 (2) by striking ‘‘power-driven wheelchair’’ and
2 inserting ‘‘complex rehabilitative power-driven wheel-
3 chair recognized by the Secretary as classified within
4 group 3 or higher’’.

5 (b) EFFECTIVE DATE.—The amendments made by
6 subsection (a) shall take effect on January 1, 2011, and
7 shall apply to power-driven wheelchairs furnished on or
8 after such date. Such amendments shall not apply to con-
9 tracts entered into under section 1847 of the Social Secu-
10 rity Act (42 U.S.C. 1395w–3) pursuant to a bid submitted
11 under such section before October 1, 2010, under sub-
12 section (a)(1)(B)(i)(I) of such section.

13 **SEC. 1142. EXTENSION OF PAYMENT RULE FOR**
14 **BRACHYTHERAPY.**

15 Section 1833(t)(16)(C) of the Social Security Act (42
16 U.S.C. 1395l(t)(16)(C)), as amended by section 142 of the
17 Medicare Improvements for Patients and Providers Act of
18 2008 (Public Law 110–275), is amended by striking, the
19 first place it appears, ‘‘January 1, 2010’’ and inserting
20 ‘‘January 1, 2012’’.

21 **SEC. 1143. HOME INFUSION THERAPY REPORT TO CON-**
22 **GRESS.**

23 Not later than 12 months after the date of enactment
24 of this Act, the Medicare Payment Advisory Commission
25 shall submit to Congress a report on the following:

1 (1) The scope of coverage for home infusion
2 therapy in the fee-for-service Medicare program
3 under title XVIII of the Social Security Act, Medi-
4 care Advantage under part C of such title, the vet-
5 eran's health care program under chapter 17 of title
6 38, United States Code, and among private payers,
7 including an analysis of the scope of services pro-
8 vided by home infusion therapy providers to their
9 patients in such programs.
10 (2) The benefits and costs of providing such
11 coverage under the Medicare program, including a
12 calculation of the potential savings achieved through
13 avoided or shortened hospital and nursing home
14 stays as a result of Medicare coverage of home infu-
15 sion therapy.
16 (3) An assessment of sources of data on the
17 costs of home infusion therapy that might be used
18 to construct payment mechanisms in the Medicare
19 program.
20 (4) Recommendations, if any, on the structure
21 of a payment system under the Medicare program
22 for home infusion therapy, including an analysis of
23 the payment methodologies used under Medicare Ad-
24 vantage plans and private health plans for the provi-

1 sion of home infusion therapy and their applicability
2 to the Medicare program.

3 **SEC. 1144. REQUIRE AMBULATORY SURGICAL CENTERS**
4 **(ASCS) TO SUBMIT COST DATA AND OTHER**
5 **DATA.**

6 (a) COST REPORTING.—
7 (1) IN GENERAL.—Section 1833(i) of the Social
8 Security Act (42 U.S.C. 1395l(i)) is amended by
9 adding at the end the following new paragraph:
10 ''(8) The Secretary shall require, as a condition of
11 the agreement described in section 1832(a)(2)(F)(i), the
12 submission of such cost report as the Secretary may speci-
13 fy, taking into account the requirements for such reports
14 under section 1815 in the case of a hospital.''.
15 (2) DEVELOPMENT OF COST REPORT.—Not
16 later than 3 years after the date of the enactment
17 of this Act, the Secretary of Health and Human
18 Services shall develop a cost report form for use
19 under section 1833(i)(8) of the Social Security Act,
20 as added by paragraph (1).
21 (3) AUDIT REQUIREMENT.—The Secretary shall
22 provide for periodic auditing of cost reports sub-
23 mitted under section 1833(i)(8) of the Social Secu-
24 rity Act, as added by paragraph (1).

1 (4) EFFECTIVE DATE.—The amendment made
2 by paragraph (1) shall apply to agreements applica-
3 ble to cost reporting periods beginning 18 months
4 after the date the Secretary develops the cost report
5 form under paragraph (2).

6 (b) ADDITIONAL DATA ON QUALITY.—

7 (1) IN GENERAL.—Section 1833(i)(7) of such
8 Act (42 U.S.C. 1395l(i)(7)) is amended—

9 (A) in subparagraph (B), by inserting
10 ''subject to subparagraph (C),'' after ''may oth-
11 erwise provide,''; and

12 (B) by adding at the end the following new
13 subparagraph:

14 ''(C) Under subparagraph (B) the Secretary shall re-
15 quire the reporting of such additional data relating to
16 quality of services furnished in an ambulatory surgical fa-
17 cility, including data on health care associated infections,
18 as the Secretary may specify.''.

19 (2) EFFECTIVE DATE.—The amendment made
20 by paragraph (1) shall to reporting for years begin-
21 ning with 2012.

22 **SEC. 1145. TREATMENT OF CERTAIN CANCER HOSPITALS.**

23 Section 1833(t) of the Social Security Act (42 U.S.C.
24 1395l(t)) is amended by adding at the end the following
25 new paragraph:

1 "(18) AUTHORIZATION OF ADJUSTMENT FOR
2 CANCER HOSPITALS.—
3 "(A) STUDY.—The Secretary shall conduct
4 a study to determine if, under the system under
5 this subsection, costs incurred by hospitals de-
6 scribed in section 1886(d)(1)(B)(v) with respect
7 to ambulatory payment classification groups ex-
8 ceed those costs incurred by other hospitals fur-
9 nishing services under this subsection (as deter-
10 mined appropriate by the Secretary).
11 "(B) AUTHORIZATION OF ADJUSTMENT.—
12 Insofar as the Secretary determines under sub-
13 paragraph (A) that costs incurred by hospitals
14 described in section 1886(d)(1)(B)(v) exceed
15 those costs incurred by other hospitals fur-
16 nishing services under this subsection, the Sec-
17 retary shall provide for an appropriate adjust-
18 ment under paragraph (2)(E) to reflect those
19 higher costs effective for services furnished on
20 or after January 1, 2011.".

21 **SEC. 1146. MEDICARE IMPROVEMENT FUND.**

22 Section 1898(b)(1)(A) of the Social Security Act (42
23 U.S.C. 1395iii(b)(1)(A)) is amended to read as follows:

1 "(A) the period beginning with fiscal year
2 2011 and ending with fiscal year 2019,
3 $8,000,000,000; and".

4 **SEC. 1147. PAYMENT FOR IMAGING SERVICES.**

5 (a) ADJUSTMENT IN PRACTICE EXPENSE TO RE-
6 FLECT HIGHER PRESUMED UTILIZATION.—Section 1848
7 of the Social Security Act (42 U.S.C. 1395w) is amend-
8 ed—
9 (1) in subsection (b)(4)—
10 (A) in subparagraph (B), by striking "sub-
11 paragraph (A)" and inserting "this paragraph";
12 and
13 (B) by adding at the end the following new
14 subparagraph:
15 "(C) ADJUSTMENT IN PRACTICE EXPENSE
16 TO REFLECT HIGHER PRESUMED UTILIZA-
17 TION.—In computing the number of practice
18 expense relative value units under subsection
19 (c)(2)(C)(ii) with respect to advanced diagnostic
20 imaging services (as defined in section
21 1834(e)(1)(B)) , the Secretary shall adjust such
22 number of units so it reflects a 75 percent
23 (rather than 50 percent) presumed rate of utili-
24 zation of imaging equipment."; and

1 (2) in subsection (c)(2)(B)(v)(II), by inserting
2 "AND OTHER PROVISIONS" after "OPD PAYMENT
3 CAP".

4 (b) ADJUSTMENT IN TECHNICAL COMPONENT "DIS-
5 COUNT" ON SINGLE-SESSION IMAGING TO CONSECUTIVE
6 BODY PARTS.—Section 1848(b)(4) of such Act is further
7 amended by adding at the end the following new subpara-
8 graph:

9 "(D) ADJUSTMENT IN TECHNICAL COMPO-
10 NENT DISCOUNT ON SINGLE-SESSION IMAGING
11 INVOLVING CONSECUTIVE BODY PARTS.—The
12 Secretary shall increase the reduction in ex-
13 penditures attributable to the multiple proce-
14 dure payment reduction applicable to the tech-
15 nical component for imaging under the final
16 rule published by the Secretary in the Federal
17 Register on November 21, 2005 (part 405 of
18 title 42, Code of Federal Regulations) from 25
19 percent to 50 percent.".

20 (c) EFFECTIVE DATE.—Except as otherwise pro-
21 vided, this section, and the amendments made by this sec-
22 tion, shall apply to services furnished on or after January
23 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

1 equipment to an individual under this sub-
2 section as of the 27th month of the 36
3 months described in clause (i), the supplier
4 furnishing such equipment as of such
5 month shall continue to furnish such
6 equipment to such individual (either di-
7 rectly or though arrangements with other
8 suppliers of such equipment) during any
9 subsequent period of medical need for the
10 remainder of the reasonable useful lifetime
11 of the equipment, as determined by the
12 Secretary, regardless of the location of the
13 individual, unless another supplier has ac-
14 cepted responsibility for continuing to fur-
15 nish such equipment during the remainder
16 of such period.''.
17 (2) EFFECTIVE DATE.—The amendments made
18 by paragraph (1) shall take effect as of the date of
19 the enactment of this Act and shall apply to the fur-
20 nishing of equipment to individuals for whom the
21 27th month of a continuous period of use of oxygen
22 equipment described in section 1834(a)(5)(F) of the
23 Social Security Act occurs on or after July 1, 2010.

1 (c) TREATMENT OF CURRENT ACCREDITATION AP-
2 PLICATIONS.—Section 1834(a)(20)(F) of such Act (42
3 U.S.C. 1395m(a)(20)(F)) is amended—
4 (1) in clause (i)—
5 (A) by striking ''clause (ii)'' and inserting
6 ''clauses (ii) and (iii)''; and
7 (B) by striking ''and'' at the end;
8 (2) by striking the period at the end of clause
9 (ii)(II) and by inserting ''; and'';
10 (3) by inserting after clause (ii) the following
11 new clause:
12 ''(iii) the requirement for accredita-
13 tion described in clause (i) shall not apply
14 for purposes of supplying diabetic testing
15 supplies, canes, and crutches in the case of
16 a pharmacy that is enrolled under section
17 1866(j) as a supplier of durable medical
18 equipment, prosthetics, orthotics, and sup-
19 plies.''; and
20 (4) by adding after and below clause (iii) the
21 following:
22 ''Any supplier that has submitted an applica-
23 tion for accreditation before August 1, 2009,
24 shall be deemed as meeting applicable stand-
25 ards and accreditation requirement under this

1 subparagraph until such time as the inde-
2 pendent accreditation organization takes action
3 on the supplier's application.''.

4 (d) RESTORING 36-MONTH OXYGEN RENTAL PE-
5 RIOD IN CASE OF SUPPLIER BANKRUPTCY FOR CERTAIN
6 INDIVIDUALS.—Section 1834(a)(5)(F) of such Act (42
7 U.S.C. 1395m(a)(5)(F)), as amended by subsection (b),
8 is further amended by adding at the end the following new
9 clause:

10 ''(iii) EXCEPTION FOR BANK-
11 RUPTCY.—If a supplier who furnishes oxy-
12 gen and oxygen equipment to an individual
13 is declared bankrupt and its assets are liq-
14 uidated and at the time of such declaration
15 and liquidation more than 24 months of
16 rental payments have been made, such in-
17 dividual may begin a new 36-month rental
18 period under this subparagraph with an-
19 other supplier of oxygen.''.

20 **SEC. 1149. MEDPAC STUDY AND REPORT ON BONE MASS**
21 **MEASUREMENT.**

22 (a) IN GENERAL.—The Medicare Payment Advisory
23 Commission shall conduct a study regarding bone mass
24 measurement, including computed tomography, duel-en-

1 ergy x-ray absorptriometry, and vertebral fracture assess-
2 ment. The study shall focus on the following:

3 (1) An assessment of the adequacy of Medicare
4 payment rates for such services, taking into account
5 costs of acquiring the necessary equipment, profes-
6 sional work time, and practice expense costs.

7 (2) The impact of Medicare payment changes
8 since 2006 on beneficiary access to bone mass meas-
9 urement benefits in general and in rural and minor-
10 ity communities specifically.

11 (3) A review of the clinically appropriate and
12 recommended use among Medicare beneficiaries and
13 how usage rates among such beneficiaries compares
14 to such recommendations.

15 (4) In conjunction with the findings under (3),
16 recommendations, if necessary, regarding methods
17 for reaching appropriate use of bone mass measure-
18 ment studies among Medicare beneficiaries.

19 (b) REPORT.—The Commission shall submit a report
20 to the Congress, not later than 9 months after the date
21 of the enactment of this Act, containing a description of
22 the results of the study conducted under subsection (a)
23 and the conclusions and recommendations, if any, regard-
24 ing each of the issues described in paragraphs (1), (2) (3)
25 and (4) of such subsection.

1 **Subtitle C—Provisions Related to**
2 **Medicare Parts A and B**

3 **SEC. 1151. REDUCING POTENTIALLY PREVENTABLE HOS-**
4 **PITAL READMISSIONS.**

5 (a) HOSPITALS.—
6 (1) IN GENERAL.—Section 1886 of the Social
7 Security Act (42 U.S.C. 1395ww), as amended by
8 section 1103(a), is amended by adding at the end
9 the following new subsection:
10 ‘‘(p) ADJUSTMENT TO HOSPITAL PAYMENTS FOR
11 EXCESS READMISSIONS.—
12 ‘‘(1) IN GENERAL.—With respect to payment
13 for discharges from an applicable hospital (as de-
14 fined in paragraph (5)(C)) occurring during a fiscal
15 year beginning on or after October 1, 2011, in order
16 to account for excess readmissions in the hospital,
17 the Secretary shall reduce the payments that would
18 otherwise be made to such hospital under subsection
19 (d) (or section 1814(b)(3), as the case may be) for
20 such a discharge by an amount equal to the product
21 of—
22 ‘‘(A) the base operating DRG payment
23 amount (as defined in paragraph (2)) for the
24 discharge; and

1 "(B) the adjustment factor (described in
2 paragraph (3)(A)) for the hospital for the fiscal
3 year.
4 "(2) BASE OPERATING DRG PAYMENT
5 AMOUNT.—
6 "(A) IN GENERAL.—Except as provided in
7 subparagraph (B), for purposes of this sub-
8 section, the term 'base operating DRG payment
9 amount' means, with respect to a hospital for a
10 fiscal year, the payment amount that would
11 otherwise be made under subsection (d) for a
12 discharge if this subsection did not apply, re-
13 duced by any portion of such amount that is at-
14 tributable to payments under subparagraphs
15 (B) and (F) of paragraph (5).
16 "(B) ADJUSTMENTS.—For purposes of
17 subparagraph (A), in the case of a hospital that
18 is paid under section 1814(b)(3), the term 'base
19 operating DRG payment amount' means the
20 payment amount under such section.
21 "(3) ADJUSTMENT FACTOR.—
22 "(A) IN GENERAL.—For purposes of para-
23 graph (1), the adjustment factor under this
24 paragraph for an applicable hospital for a fiscal
25 year is equal to the greater of—

1 "(i) the ratio described in subpara-
2 graph (B) for the hospital for the applica-
3 ble period (as defined in paragraph (5)(D))
4 for such fiscal year; or
5 "(ii) the floor adjustment factor speci-
6 fied in subparagraph (C).
7 "(B) RATIO.—The ratio described in this
8 subparagraph for a hospital for an applicable
9 period is equal to 1 minus the ratio of—
10 "(i) the aggregate payments for ex-
11 cess readmissions (as defined in paragraph
12 (4)(A)) with respect to an applicable hos-
13 pital for the applicable period; and
14 "(ii) the aggregate payments for all
15 discharges (as defined in paragraph
16 (4)(B)) with respect to such applicable
17 hospital for such applicable period.
18 "(C) FLOOR ADJUSTMENT FACTOR.—For
19 purposes of subparagraph (A), the floor adjust-
20 ment factor specified in this subparagraph
21 for—
22 "(i) fiscal year 2012 is 0.99;
23 "(ii) fiscal year 2013 is 0.98;
24 "(iii) fiscal year 2014 is 0.97; or
25 "(iv) a subsequent fiscal year is 0.95.

1 "(4) AGGREGATE PAYMENTS, EXCESS READMIS-
2 SION RATIO DEFINED.—For purposes of this sub-
3 section:
4 "(A) AGGREGATE PAYMENTS FOR EXCESS
5 READMISSIONS.—The term 'aggregate payments
6 for excess readmissions' means, for a hospital
7 for a fiscal year, the sum, for applicable condi-
8 tions (as defined in paragraph (5)(A)), of the
9 product, for each applicable condition, of—
10 "(i) the base operating DRG payment
11 amount for such hospital for such fiscal
12 year for such condition;
13 "(ii) the number of admissions for
14 such condition for such hospital for such
15 fiscal year; and
16 "(iii) the excess readmissions ratio (as
17 defined in subparagraph (C)) for such hos-
18 pital for the applicable period for such fis-
19 cal year minus 1.
20 "(B) AGGREGATE PAYMENTS FOR ALL DIS-
21 CHARGES.—The term 'aggregate payments for
22 all discharges' means, for a hospital for a fiscal
23 year, the sum of the base operating DRG pay-
24 ment amounts for all discharges for all condi-
25 tions from such hospital for such fiscal year.

1 "(C) EXCESS READMISSION RATIO.—
2 "(i) IN GENERAL.—Subject to clauses
3 (ii) and (iii), the term 'excess readmissions
4 ratio' means, with respect to an applicable
5 condition for a hospital for an applicable
6 period, the ratio (but not less than 1.0)
7 of—
8 "(I) the risk adjusted readmis-
9 sions based on actual readmissions, as
10 determined consistent with a readmis-
11 sion measure methodology that has
12 been endorsed under paragraph
13 (5)(A)(ii)(I), for an applicable hospital
14 for such condition with respect to the
15 applicable period; to
16 "(II) the risk adjusted expected
17 readmissions (as determined con-
18 sistent with such a methodology) for
19 such hospital for such condition with
20 respect to such applicable period.
21 "(ii) EXCLUSION OF CERTAIN RE-
22 ADMISSIONS.—For purposes of clause (i),
23 with respect to a hospital, excess readmis-
24 sions shall not include readmissions for an
25 applicable condition for which there are

1 fewer than a minimum number (as deter-
2 mined by the Secretary) of discharges for
3 such applicable condition for the applicable
4 period and such hospital.
5 ''(iii) ADJUSTMENT.—In order to pro-
6 mote a reduction over time in the overall
7 rate of readmissions for applicable condi-
8 tions, the Secretary may provide, beginning
9 with discharges for fiscal year 2014, for
10 the determination of the excess readmis-
11 sions ratio under subparagraph (C) to be
12 based on a ranking of hospitals by read-
13 mission ratios (from lower to higher read-
14 mission ratios) normalized to a benchmark
15 that is lower than the 50th percentile.
16 ''(5) DEFINITIONS.—For purposes of this sub-
17 section:
18 ''(A) APPLICABLE CONDITION.—The term
19 'applicable condition' means, subject to sub-
20 paragraph (B), a condition or procedure se-
21 lected by the Secretary among conditions and
22 procedures for which—
23 ''(i) readmissions (as defined in sub-
24 paragraph (E)) that represent conditions
25 or procedures that are high volume or high

1 expenditures under this title (or other cri-
2 teria specified by the Secretary); and
3 “(ii) measures of such readmissions—
4 “(I) have been endorsed by the
5 entity with a contract under section
6 1890(a); and
7 “(II) such endorsed measures
8 have appropriate exclusions for re-
9 admissions that are unrelated to the
10 prior discharge (such as a planned re-
11 admission or transfer to another ap-
12 plicable hospital).
13 “(B) EXPANSION OF APPLICABLE CONDI-
14 TIONS.—Beginning with fiscal year 2013, the
15 Secretary shall expand the applicable conditions
16 beyond the 3 conditions for which measures
17 have been endorsed as described in subpara-
18 graph (A)(ii)(I) as of the date of the enactment
19 of this subsection to the additional 4 conditions
20 that have been so identified by the Medicare
21 Payment Advisory Commission in its report to
22 Congress in June 2007 and to other conditions
23 and procedures which may include an all-condi-
24 tion measure of readmissions, as determined
25 appropriate by the Secretary. In expanding

1 such applicable conditions, the Secretary shall
2 seek the endorsement described in subpara-
3 graph (A)(ii)(I) but may apply such measures
4 without such an endorsement.
5 "(C) APPLICABLE HOSPITAL.—The term
6 'applicable hospital' means a subsection (d) hos-
7 pital or a hospital that is paid under section
8 1814(b)(3).
9 "(D) APPLICABLE PERIOD.—The term 'ap-
10 plicable period' means, with respect to a fiscal
11 year, such period as the Secretary shall specify
12 for purposes of determining excess readmis-
13 sions.
14 "(E) READMISSION.—The term 'readmis-
15 sion' means, in the case of an individual who is
16 discharged from an applicable hospital, the ad-
17 mission of the individual to the same or another
18 applicable hospital within a time period speci-
19 fied by the Secretary from the date of such dis-
20 charge. Insofar as the discharge relates to an
21 applicable condition for which there is an en-
22 dorsed measure described in subparagraph
23 (A)(ii)(I), such time period (such as 30 days)
24 shall be consistent with the time period speci-
25 fied for such measure.

1 "(6) LIMITATIONS ON REVIEW.—There shall be
2 no administrative or judicial review under section
3 1869, section 1878, or otherwise of—
4 "(A) the determination of base operating
5 DRG payment amounts;
6 "(B) the methodology for determining the
7 adjustment factor under paragraph (3), includ-
8 ing excess readmissions ratio under paragraph
9 (4)(C), aggregate payments for excess readmis-
10 sions under paragraph (4)(A), and aggregate
11 payments for all discharges under paragraph
12 (4)(B), and applicable periods and applicable
13 conditions under paragraph (5);
14 "(C) the measures of readmissions as de-
15 scribed in paragraph (5)(A)(ii); and
16 "(D) the determination of a targeted hos-
17 pital under paragraph (8)(B)(i), the increase in
18 payment under paragraph (8)(B)(ii), the aggre-
19 gate cap under paragraph (8)(C)(i), the hos-
20 pital-specific limit under paragraph (8)(C)(ii),
21 and the form of payment made by the Secretary
22 under paragraph (8)(D).
23 "(7) MONITORING INAPPROPRIATE CHANGES IN
24 ADMISSIONS PRACTICES.—The Secretary shall mon-
25 itor the activities of applicable hospitals to determine

1 if such hospitals have taken steps to avoid patients
2 at risk in order to reduce the likelihood of increasing
3 readmissions for applicable conditions. If the Sec-
4 retary determines that such a hospital has taken
5 such a step, after notice to the hospital and oppor-
6 tunity for the hospital to undertake action to allevi-
7 ate such steps, the Secretary may impose an appro-
8 priate sanction.
9 "(8) ASSISTANCE TO CERTAIN HOSPITALS.—
10 "(A) IN GENERAL.—For purposes of pro-
11 viding funds to applicable hospitals to take
12 steps described in subparagraph (E) to address
13 factors that may impact readmissions of indi-
14 viduals who are discharged from such a hos-
15 pital, for fiscal years beginning on or after Oc-
16 tober 1, 2011, the Secretary shall make a pay-
17 ment adjustment for a hospital described in
18 subparagraph (B), with respect to each such
19 fiscal year, by a percent estimated by the Sec-
20 retary to be consistent with subparagraph (C).
21 "(B) TARGETED HOSPITALS.—Subpara-
22 graph (A) shall apply to an applicable hospital
23 that—
24 "(i) received (or, in the case of an
25 1814(b)(3) hospital, otherwise would have

1 been eligible to receive) $10,000,000 or
2 more in disproportionate share payments
3 using the latest available data as estimated
4 by the Secretary; and
5 ''(ii) provides assurances satisfactory
6 to the Secretary that the increase in pay-
7 ment under this paragraph shall be used
8 for purposes described in subparagraph
9 (E).
10 ''(C) CAPS.—
11 ''(i) AGGREGATE CAP.—The aggregate
12 amount of the payment adjustment under
13 this paragraph for a fiscal year shall not
14 exceed 5 percent of the estimated dif-
15 ference in the spending that would occur
16 for such fiscal year with and without appli-
17 cation of the adjustment factor described
18 in paragraph (3) and applied pursuant to
19 paragraph (1).
20 ''(ii) HOSPITAL-SPECIFIC LIMIT.—The
21 aggregate amount of the payment adjust-
22 ment for a hospital under this paragraph
23 shall not exceed the estimated difference in
24 spending that would occur for such fiscal
25 year for such hospital with and without ap-

1 plication of the adjustment factor de-
2 scribed in paragraph (3) and applied pur-
3 suant to paragraph (1).
4 "(D) FORM OF PAYMENT.—The Secretary
5 may make the additional payments under this
6 paragraph on a lump sum basis, a periodic
7 basis, a claim by claim basis, or otherwise.
8 "(E) USE OF ADDITIONAL PAYMENT.—
9 Funding under this paragraph shall be used by
10 targeted hospitals for transitional care activities
11 designed to address the patient noncompliance
12 issues that result in higher than normal read-
13 mission rates, such as one or more of the fol-
14 lowing:
15 "(i) Providing care coordination serv-
16 ices to assist in transitions from the tar-
17 geted hospital to other settings.
18 "(ii) Hiring translators and inter-
19 preters.
20 "(iii) Increasing services offered by
21 discharge planners.
22 "(iv) Ensuring that individuals receive
23 a summary of care and medication orders
24 upon discharge.

1 "(v) Developing a quality improve-
2 ment plan to assess and remedy prevent-
3 able readmission rates.
4 "(vi) Assigning discharged individuals
5 to a medical home.
6 "(vii) Doing other activities as deter-
7 mined appropriate by the Secretary.
8 "(F) GAO REPORT ON USE OF FUNDS.—
9 Not later than 3 years after the date on which
10 funds are first made available under this para-
11 graph, the Comptroller General of the United
12 States shall submit to Congress a report on the
13 use of such funds.
14 "(G) DISPROPORTIONATE SHARE HOS-
15 PITAL PAYMENT.—In this paragraph, the term
16 'disproportionate share hospital payment'
17 means an additional payment amount under
18 subsection (d)(5)(F).".
19 (b) APPLICATION TO CRITICAL ACCESS HOS-
20 PITALS.—Section 1814(l) of the Social Security Act (42
21 U.S.C. 1395f(l)) is amended—
22 (1) in paragraph (5)—
23 (A) by striking "and" at the end of sub-
24 paragraph (C);

1 (B) by striking the period at the end of
2 subparagraph (D) and inserting "; and";
3 (C) by inserting at the end the following
4 new subparagraph:
5 "(E) The methodology for determining the ad-
6 justment factor under paragraph (5), including the
7 determination of aggregate payments for actual and
8 expected readmissions, applicable periods, applicable
9 conditions and measures of readmissions."; and
10 (D) by redesignating such paragraph as
11 paragraph (6); and
12 (2) by inserting after paragraph (4) the fol-
13 lowing new paragraph:
14 "(5) The adjustment factor described in section
15 1886(p)(3) shall apply to payments with respect to a crit-
16 ical access hospital with respect to a cost reporting period
17 beginning in fiscal year 2012 and each subsequent fiscal
18 year (after application of paragraph (4) of this subsection)
19 in a manner similar to the manner in which such section
20 applies with respect to a fiscal year to an applicable hos-
21 pital as described in section 1886(p)(2).".
22 (c) POST ACUTE CARE PROVIDERS.—
23 (1) INTERIM POLICY.—
24 (A) IN GENERAL.—With respect to a read-
25 mission to an applicable hospital or a critical

1 access hospital (as described in section 1814(l)
2 of the Social Security Act) from a post acute
3 care provider (as defined in paragraph (3)) and
4 such a readmission is not governed by section
5 412.531 of title 42, Code of Federal Regula-
6 tions, if the claim submitted by such a post-
7 acute care provider under title XVIII of the So-
8 cial Security Act indicates that the individual
9 was readmitted to a hospital from such a post-
10 acute care provider or admitted from home and
11 under the care of a home health agency within
12 30 days of an initial discharge from an applica-
13 ble hospital or critical access hospital, the pay-
14 ment under such title on such claim shall be the
15 applicable percent specified in subparagraph
16 (B) of the payment that would otherwise be
17 made under the respective payment system
18 under such title for such post-acute care pro-
19 vider if this subsection did not apply.

20 (B) APPLICABLE PERCENT DEFINED.—For
21 purposes of subparagraph (A), the applicable
22 percent is—

23 (i) for fiscal or rate year 2012 is
24 0.996;

1 (ii) for fiscal or rate year 2013 is
2 0.993; and
3 (iii) for fiscal or rate year 2014 is
4 0.99.
5 (C) EFFECTIVE DATE.—Subparagraph (1)
6 shall apply to discharges or services furnished
7 (as the case may be with respect to the applica-
8 ble post acute care provider) on or after the
9 first day of the fiscal year or rate year, begin-
10 ning on or after October 1, 2011, with respect
11 to the applicable post acute care provider.
12 (2) DEVELOPMENT AND APPLICATION OF PER-
13 FORMANCE MEASURES.—
14 (A) IN GENERAL.—The Secretary of
15 Health and Human Services shall develop ap-
16 propriate measures of readmission rates for
17 post acute care providers. The Secretary shall
18 seek endorsement of such measures by the enti-
19 ty with a contract under section 1890(a) of the
20 Social Security Act but may adopt and apply
21 such measures under this paragraph without
22 such an endorsement. The Secretary shall ex-
23 pand such measures in a manner similar to the
24 manner in which applicable conditions are ex-
25 panded under paragraph (5)(B) of section

1 1886(p) of the Social Security Act, as added by
2 subsection (a).
3 (B) IMPLEMENTATION.—The Secretary
4 shall apply, on or after October 1, 2014, with
5 respect to post acute care providers, policies
6 similar to the policies applied with respect to
7 applicable hospitals and critical access hospitals
8 under the amendments made by subsection (a).
9 The provisions of paragraph (1) shall apply
10 with respect to any period on or after October
11 1, 2014, and before such application date de-
12 scribed in the previous sentence in the same
13 manner as such provisions apply with respect to
14 fiscal or rate year 2014.
15 (C) MONITORING AND PENALTIES.—The
16 provisions of paragraph (7) of such section
17 1886(p) shall apply to providers under this
18 paragraph in the same manner as they apply to
19 hospitals under such section.
20 (3) DEFINITIONS.—For purposes of this sub-
21 section:
22 (A) POST ACUTE CARE PROVIDER.—The
23 term "post acute care provider" means—

1 (i) a skilled nursing facility (as de-
2 fined in section 1819(a) of the Social Secu-
3 rity Act);
4 (ii) an inpatient rehabilitation facility
5 (described in section 1886(h)(1)(A) of such
6 Act);
7 (iii) a home health agency (as defined
8 in section 1861(o) of such Act); and
9 (iv) a long term care hospital (as de-
10 fined in section 1861(ccc) of such Act).
11 (B) OTHER TERMS .—The terms ''applica-
12 ble condition'', ''applicable hospital'', and ''re-
13 admission'' have the meanings given such terms
14 in section 1886(p)(5) of the Social Security
15 Act, as added by subsection (a)(1).
16 (d) PHYSICIANS.—
17 (1) STUDY.—The Secretary of Health and
18 Human Services shall conduct a study to determine
19 how the readmissions policy described in the pre-
20 vious subsections could be applied to physicians.
21 (2) CONSIDERATIONS.—In conducting the
22 study, the Secretary shall consider approaches such
23 as—
24 (A) creating a new code (or codes) and
25 payment amount (or amounts) under the fee

1 schedule in section 1848 of the Social Security
2 Act (in a budget neutral manner) for services
3 furnished by an appropriate physician who sees
4 an individual within the first week after dis-
5 charge from a hospital or critical access hos-
6 pital;
7 (B) developing measures of rates of read-
8 mission for individuals treated by physicians;
9 (C) applying a payment reduction for phy-
10 sicians who treat the patient during the initial
11 admission that results in a readmission; and
12 (D) methods for attributing payments or
13 payment reductions to the appropriate physi-
14 cian or physicians.
15 (3) REPORT.—The Secretary shall issue a pub-
16 lic report on such study not later than the date that
17 is one year after the date of the enactment of this
18 Act.
19 (e) FUNDING.—For purposes of carrying out the pro-
20 visions of this section, in addition to funds otherwise avail-
21 able, out of any funds in the Treasury not otherwise ap-
22 propriated, there are appropriated to the Secretary of
23 Health and Human Services for the Center for Medicare
24 & Medicaid Services Program Management Account
25 $25,000,000 for each fiscal year beginning with 2010.

1 Amounts appropriated under this subsection for a fiscal
2 year shall be available until expended.

3 **SEC. 1152. POST ACUTE CARE SERVICES PAYMENT REFORM**
4 **PLAN AND BUNDLING PILOT PROGRAM.**

5 (a) PLAN.—

6 (1) IN GENERAL.—The Secretary of Health and
7 Human Services (in this section referred to as the
8 ''Secretary'') shall develop a detailed plan to reform
9 payment for post acute care (PAC) services under
10 the Medicare program under title XVIII of the So-
11 cial Security Act (in this section referred to as the
12 ''Medicare program)''. The goals of such payment
13 reform are to—

14 (A) improve the coordination, quality, and
15 efficiency of such services; and

16 (B) improve outcomes for individuals such
17 as reducing the need for readmission to hos-
18 pitals from providers of such services.

19 (2) BUNDLING POST ACUTE SERVICES.—The
20 plan described in paragraph (1) shall include de-
21 tailed specifications for a bundled payment for post
22 acute services (in this section referred to as the
23 ''post acute care bundle''), and may include other
24 approaches determined appropriate by the Secretary.

1 (3) POST ACUTE SERVICES.—For purposes of
2 this section, the term ''post acute services'' means
3 services for which payment may be made under the
4 Medicare program that are furnished by skilled
5 nursing facilities, inpatient rehabilitation facilities,
6 long term care hospitals, hospital based outpatient
7 rehabilitation facilities and home health agencies to
8 an individual after discharge of such individual from
9 a hospital, and such other services determined ap-
10 propriate by the Secretary.

11 (b) DETAILS.—The plan described in subsection
12 (a)(1) shall include consideration of the following issues:

13 (1) The nature of payments under a post acute
14 care bundle, including the type of provider or entity
15 to whom payment should be made, the scope of ac-
16 tivities and services included in the bundle, whether
17 payment for physicians' services should be included
18 in the bundle, and the period covered by the bundle.

19 (2) Whether the payment should be consoli-
20 dated with the payment under the inpatient prospec-
21 tive system under section 1886 of the Social Secu-
22 rity Act (in this section referred to as MS–DRGs)
23 or a separate payment should be established for such
24 bundle, and if a separate payment is established,

1 whether it should be made only upon use of post
2 acute care services or for every discharge.
3 (3) Whether the bundle should be applied
4 across all categories of providers of inpatient serv-
5 ices (including critical access hospitals) and post
6 acute care services or whether it should be limited
7 to certain categories of providers, services, or dis-
8 charges, such as high volume or high cost MS–
9 DRGs.
10 (4) The extent to which payment rates could be
11 established to achieve offsets for efficiencies that
12 could be expected to be achieved with a bundle pay-
13 ment, whether such rates should be established on a
14 national basis or for different geographic areas,
15 should vary according to discharge, case mix,
16 outliers, and geographic differences in wages or
17 other appropriate adjustments, and how to update
18 such rates.
19 (5) The nature of protections needed for indi-
20 viduals under a system of bundled payments to en-
21 sure that individuals receive quality care, are fur-
22 nished the level and amount of services needed as
23 determined by an appropriate assessment instru-
24 ment, are offered choice of provider, and the extent
25 to which transitional care services would improve

1 quality of care for individuals and the functioning of
2 a bundled post-acute system.
3 (6) The nature of relationships that may be re-
4 quired between hospitals and providers of post acute
5 care services to facilitate bundled payments, includ-
6 ing the application of gainsharing, anti-referral,
7 anti-kickback, and anti-trust laws.
8 (7) Quality measures that would be appropriate
9 for reporting by hospitals and post acute providers
10 (such as measures that assess changes in functional
11 status and quality measures appropriate for each
12 type of post acute services provider including how
13 the reporting of such quality measures could be co-
14 ordinated with other reporting of such quality meas-
15 ures by such providers otherwise required).
16 (8) How cost-sharing for a post acute care bun-
17 dle should be treated relative to current rules for
18 cost-sharing for inpatient hospital, home health,
19 skilled nursing facility, and other services.
20 (9) How other programmatic issues should be
21 treated in a post acute care bundle, including rules
22 specific to various types of post-acute providers such
23 as the post-acute transfer policy, three-day hospital
24 stay to qualify for services furnished by skilled nurs-
25 ing facilities, and the coordination of payments and

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

1 (D) if patient functional status measures
2 are appropriate for the analysis, to the extent
3 practical, build upon the CARE tool being de-
4 veloped pursuant to section 5008 of the Deficit
5 Reduction Act of 2005.
6 (d) ADMINISTRATION.—
7 (1) FUNDING.—For purposes of carrying out
8 the provisions of this section, in addition to funds
9 otherwise available, out of any funds in the Treasury
10 not otherwise appropriated, there are appropriated
11 to the Secretary for the Center for Medicare & Med-
12 icaid Services Program Management Account
13 $15,000,000 for each of the fiscal years 2010
14 through 2012. Amounts appropriated under this
15 paragraph for a fiscal year shall be available until
16 expended.
17 (2) EXPEDITED DATA COLLECTION.—Chapter
18 35 of title 44, United States Code shall not apply to
19 this section.
20 (e) PUBLIC REPORTS.—
21 (1) INTERIM REPORTS.—The Secretary shall
22 issue interim public reports on a periodic basis on
23 the plan described in subsection (a)(1), the issues
24 described in subsection (b), and impact analyses as
25 the Secretary determines appropriate.

1 (2) FINAL REPORT.—Not later than the date
2 that is 3 years after the date of the enactment of
3 this Act, the Secretary shall issue a final public re-
4 port on such plan, including analysis of issues de-
5 scribed in subsection (b) and impact analyses.

6 (f) CONVERSION OF ACUTE CARE EPISODE DEM-
7 ONSTRATION TO PILOT PROGRAM AND EXPANSION TO IN-
8 CLUDE POST ACUTE SERVICES.—

9 (1) IN GENERAL.—Part E of title XVIII of the
10 Social Security Act is amended by inserting after
11 section 1866C the following new section:

12 **"SEC. 1866D. CONVERSION OF ACUTE CARE EPISODE DEM-**
13 **ONSTRATION TO PILOT PROGRAM AND EX-**
14 **PANSION TO INCLUDE POST ACUTE SERV-**
15 **ICES.**

16 "(a) CONVERSION AND EXPANSION.—

17 "(1) IN GENERAL.—By not later than January
18 1, 2011, the Secretary shall, for the purpose of pro-
19 moting the use of bundled payments to promote effi-
20 cient and high quality delivery of care—

21 "(A) convert the acute care episode dem-
22 onstration program conducted under section
23 1866C to a pilot program; and

24 "(B) subject to subsection (c), expand such
25 program as so converted to include post acute

1 services and such other services the Secretary
2 determines to be appropriate, which may in-
3 clude transitional services.
4 "(2) BUNDLED PAYMENT STRUCTURES.—
5 "(A) IN GENERAL.—In carrying out para-
6 graph (1), the Secretary may apply bundled
7 payments with respect to—
8 "(i) hospitals and physicians;
9 "(ii) hospitals and post-acute care
10 providers;
11 "(iii) hospitals, physicians, and post-
12 acute care providers; or
13 "(iv) combinations of post-acute pro-
14 viders.
15 "(B) FURTHER APPLICATION.—
16 "(i) IN GENERAL.—In carrying out
17 paragraph (1), the Secretary shall apply
18 bundled payments in a manner so as to in-
19 clude collaborative care networks and con-
20 tinuing care hospitals.
21 "(ii) COLLABORATIVE CARE NETWORK
22 DEFINED.—For purposes of this subpara-
23 graph, the term 'collaborative care net-
24 work' means a consortium of health care
25 providers that provides a comprehensive

1 range of coordinated and integrated health
2 care services to low-income patient popu-
3 lations (including the uninsured) which
4 may include coordinated and comprehen-
5 sive care by safety net providers to reduce
6 any unnecessary use of items and services
7 furnished in emergency departments, man-
8 age chronic conditions, improve quality and
9 efficiency of care, increase preventive serv-
10 ices, and promote adherence to post-acute
11 and follow-up care plans.
12 "(iii) CONTINUING CARE HOSPITAL
13 DEFINED.—For purposes of this subpara-
14 graph, the term 'continuing care hospital'
15 means an entity that has demonstrated the
16 ability to meet patient care and patient
17 safety standards and that provides under
18 common management the medical and re-
19 habilitation services provided in inpatient
20 rehabilitation hospitals and units (as de-
21 fined in section 1886(d)(1)(B)(ii)), long-
22 term care hospitals (as defined in section
23 1886(d)(1)(B)(iv)(I)), and skilled nursing
24 facilities (as defined in section 1819(a))

1 that are located in a hospital described in
2 section 1886(d).

3 "(b) SCOPE.—The pilot program under subsection
4 (a) may include additional geographic areas and additional
5 conditions which account for significant program spend-
6 ing, as defined by the Secretary. Nothing in this sub-
7 section shall be construed as limiting the number of hos-
8 pital and physician groups or the number of hospital and
9 post-acute provider groups that may participate in the
10 pilot program.

11 "(c) LIMITATION.—The Secretary shall only expand
12 the pilot program under subsection (a) if the Secretary
13 finds that—

14 "(1) the demonstration program under section
15 1866C and pilot program under this section main-
16 tain or increase the quality of care received by indi-
17 viduals enrolled under this title; and

18 "(2) such demonstration program and pilot pro-
19 gram reduce program expenditures and, based on
20 the certification under subsection (d), that the ex-
21 pansion of such pilot program would result in esti-
22 mated spending that would be less than what spend-
23 ing would otherwise be in the absence of this section.

24 "(d) CERTIFICATION.—For purposes of subsection
25 (c), the Chief Actuary of the Centers for Medicare & Med-

1 icaid Services shall certify whether expansion of the pilot
2 program under this section would result in estimated
3 spending that would be less than what spending would
4 otherwise be in the absence of this section.

5 ''(e) VOLUNTARY PARTICIPATION.—Nothing in this
6 paragraph shall be construed as requiring the participa-
7 tion of an entity in the pilot program under this section.

8 ''(f) EVALUATION ON COST AND QUALITY OF
9 CARE.—The Secretary shall conduct an evaluation of the
10 pilot program under subsection (a) to study the effect of
11 such program on costs and quality of care. The findings
12 of such evaluation shall be included in the final report re-
13 quired under section 1152(e)(2) of America's Affordable
14 Health Choices Act of 2009.

15 ''(g) STUDY OF ADDITIONAL BUNDLING AND EPI-
16 SODE-BASED PAYMENT FOR PHYSICIANS' SERVICES.—

17 ''(1) IN GENERAL.—The Secretary shall provide
18 for a study of and development of a plan for testing
19 additional ways to increase bundling of payments for
20 physicians in connection with an episode of care,
21 such as in connection with outpatient hospital serv-
22 ices or services rendered in physicians' offices, other
23 than those provided under the pilot program.

1 "(2) APPLICATION.—The Secretary may imple-
2 ment such a plan through a demonstration pro-
3 gram.".
4 (2) CONFORMING AMENDMENT.—Section
5 1866C(b) of the Social Security Act (42 U.S.C.
6 1395cc–3(b)) is amended by striking "The Sec-
7 retary" and inserting "Subject to section 1866D, the
8 Secretary".
9 **SEC. 1153. HOME HEALTH PAYMENT UPDATE FOR 2010.**
10 Section 1895(b)(3)(B)(ii) of the Social Security Act
11 (42 U.S.C. 1395fff(b)(3)(B)(ii)) is amended—
12 (1) in subclause (IV), by striking "and";
13 (2) by redesignating subclause (V) as subclause
14 (VII); and
15 (3) by inserting after subclause (IV) the fol-
16 lowing new subclauses:
17 "(V) 2007, 2008, and 2009, sub-
18 ject to clause (v), the home health
19 market basket percentage increase;
20 "(VI) 2010, subject to clause (v),
21 0 percent; and".

1 **SEC. 1154. PAYMENT ADJUSTMENTS FOR HOME HEALTH**
2 **CARE.**
3 (a) ACCELERATION OF ADJUSTMENT FOR CASE MIX
4 CHANGES.—Section 1895(b)(3)(B) of the Social Security
5 Act (42 U.S.C. 1395fff(b)(3)(B)) is amended—
6 (1) in clause (iv), by striking ''Insofar as'' and
7 inserting ''Subject to clause (vi), insofar as''; and
8 (2) by adding at the end the following new
9 clause:
10 ''(vi) SPECIAL RULE FOR CASE MIX
11 CHANGES FOR 2011.—
12 ''(I) IN GENERAL.—With respect
13 to the case mix adjustments estab-
14 lished in section 484.220(a) of title
15 42, Code of Federal Regulations, the
16 Secretary shall apply, in 2010, the ad-
17 justment established in paragraph (3)
18 of such section for 2011, in addition
19 to applying the adjustment established
20 in paragraph (2) for 2010.
21 ''(II) CONSTRUCTION.—Nothing
22 in this clause shall be construed as
23 limiting the amount of adjustment for
24 case mix for 2010 or 2011 if more re-
25 cent data indicate an appropriate ad-
26 justment that is greater than the

1 amount established in the section de-
2 scribed in subclause (I).''.
3 (b) REBASING HOME HEALTH PROSPECTIVE PAY-
4 MENT AMOUNT.—Section 1895(b)(3)(A) of the Social Se-
5 curity Act (42 U.S.C. 1395fff(b)(3)(A)) is amended—
6 (1) in clause (i)—
7 (A) in subclause (III), by inserting ''and
8 before 2011'' after ''after the period described
9 in subclause (II)''; and
10 (B) by inserting after subclause (III) the
11 following new subclauses:
12 ''(IV) Subject to clause (iii)(I),
13 for 2011, such amount (or amounts)
14 shall be adjusted by a uniform per-
15 centage determined to be appropriate
16 by the Secretary based on analysis of
17 factors such as changes in the average
18 number and types of visits in an epi-
19 sode, the change in intensity of visits
20 in an episode, growth in cost per epi-
21 sode, and other factors that the Sec-
22 retary considers to be relevant.
23 ''(V) Subject to clause (iii)(II),
24 for a year after 2011, such a amount
25 (or amounts) shall be equal to the

1 amount (or amounts) determined
2 under this clause for the previous
3 year, updated under subparagraph
4 (B).''; and
5 (2) by adding at the end the following new
6 clause:
7 ''(iii) SPECIAL RULE IN CASE OF IN-
8 ABILITY TO EFFECT TIMELY REBASING.—
9 ''(I) APPLICATION OF PROXY
10 AMOUNT FOR 2011.—If the Secretary
11 is not able to compute the amount (or
12 amounts) under clause (i)(IV) so as to
13 permit, on a timely basis, the applica-
14 tion of such clause for 2011, the Sec-
15 retary shall substitute for such
16 amount (or amounts) 95 percent of
17 the amount (or amounts) that would
18 otherwise be specified under clause
19 (i)(III) if it applied for 2011.
20 ''(II) ADJUSTMENT FOR SUBSE-
21 QUENT YEARS BASED ON DATA.—If
22 the Secretary applies subclause (I),
23 the Secretary before July 1, 2011,
24 shall compare the amount (or
25 amounts) applied under such sub-

1 clause with the amount (or amounts)
2 that should have been applied under
3 clause (i)(IV). The Secretary shall de-
4 crease or increase the prospective pay-
5 ment amount (or amounts) under
6 clause (i)(V) for 2012 (or, at the Sec-
7 retary's discretion, over a period of
8 several years beginning with 2012) by
9 the amount (if any) by which the
10 amount (or amounts) applied under
11 subclause (I) is greater or less, re-
12 spectively, than the amount (or
13 amounts) that should have been ap-
14 plied under clause (i)(IV).''.

15 **SEC. 1155. INCORPORATING PRODUCTIVITY IMPROVE-**
16 **MENTS INTO MARKET BASKET UPDATE FOR**
17 **HOME HEALTH SERVICES.**

18 (a) IN GENERAL.—Section 1895(b)(3)(B) of the So-
19 cial Security Act (42 U.S.C. 1395fff(b)(3)(B)) is amend-
20 ed—

21 (1) in clause (iii), by inserting ''(including being
22 subject to the productivity adjustment described in
23 section 1886(b)(3)(B)(iii)(II))'' after ''in the same
24 manner''; and

1 (2) in clause (v)(I), by inserting "(but not
2 below 0)" after "reduced".
3 (b) EFFECTIVE DATE.—The amendment made by
4 subsection (a) shall apply to home health market basket
5 percentage increases for years beginning with 2010.

6 **SEC. 1156. LIMITATION ON MEDICARE EXCEPTIONS TO THE**
7 **PROHIBITION ON CERTAIN PHYSICIAN RE-**
8 **FERRALS MADE TO HOSPITALS.**

9 (a) IN GENERAL.—Section 1877 of the Social Secu-
10 rity Act (42 U.S.C. 1395nn) is amended—
11 (1) in subsection (d)(2)—
12 (A) in subparagraph (A), by striking
13 "and" at the end;
14 (B) in subparagraph (B), by striking the
15 period at the end and inserting "; and"; and
16 (C) by adding at the end the following new
17 subparagraph:
18 "(C) in the case where the entity is a hos-
19 pital, the hospital meets the requirements of
20 paragraph (3)(D).";
21 (2) in subsection (d)(3)—
22 (A) in subparagraph (B), by striking
23 "and" at the end;
24 (B) in subparagraph (C), by striking the
25 period at the end and inserting "; and"; and

1 (C) by adding at the end the following new
2 subparagraph:
3 "(D) the hospital meets the requirements
4 described in subsection (i)(1).";
5 (3) by amending subsection (f) to read as fol-
6 lows:
7 "(f) REPORTING AND DISCLOSURE REQUIRE-
8 MENTS.—
9 "(1) IN GENERAL.—Each entity providing cov-
10 ered items or services for which payment may be
11 made under this title shall provide the Secretary
12 with the information concerning the entity's owner-
13 ship, investment, and compensation arrangements,
14 including—
15 "(A) the covered items and services pro-
16 vided by the entity, and
17 "(B) the names and unique physician iden-
18 tification numbers of all physicians with an
19 ownership or investment interest (as described
20 in subsection (a)(2)(A)), or with a compensa-
21 tion arrangement (as described in subsection
22 (a)(2)(B)), in the entity, or whose immediate
23 relatives have such an ownership or investment
24 interest or who have such a compensation rela-
25 tionship with the entity.

1 Such information shall be provided in such form,
2 manner, and at such times as the Secretary shall
3 specify. The requirement of this subsection shall not
4 apply to designated health services provided outside
5 the United States or to entities which the Secretary
6 determines provide services for which payment may
7 be made under this title very infrequently.

8 "(2) REQUIREMENTS FOR HOSPITALS WITH
9 PHYSICIAN OWNERSHIP OR INVESTMENT.—In the
10 case of a hospital that meets the requirements de-
11 scribed in subsection (i)(1), the hospital shall—

12 "(A) submit to the Secretary an initial re-
13 port, and periodic updates at a frequency deter-
14 mined by the Secretary, containing a detailed
15 description of the identity of each physician
16 owner and physician investor and any other
17 owners or investors of the hospital;

18 "(B) require that any referring physician
19 owner or investor discloses to the individual
20 being referred, by a time that permits the indi-
21 vidual to make a meaningful decision regarding
22 the receipt of services, as determined by the
23 Secretary, the ownership or investment interest,
24 as applicable, of such referring physician in the
25 hospital; and

1 "(C) disclose the fact that the hospital is
2 partially or wholly owned by one or more physi-
3 cians or has one or more physician investors—
4 "(i) on any public website for the hos-
5 pital; and
6 "(ii) in any public advertising for the
7 hospital.
8 The information to be reported or disclosed under
9 this paragraph shall be provided in such form, man-
10 ner, and at such times as the Secretary shall specify.
11 The requirements of this paragraph shall not apply
12 to designated health services furnished outside the
13 United States or to entities which the Secretary de-
14 termines provide services for which payment may be
15 made under this title very infrequently.
16 "(3) PUBLICATION OF INFORMATION.—The
17 Secretary shall publish, and periodically update, the
18 information submitted by hospitals under paragraph
19 (2)(A) on the public Internet website of the Centers
20 for Medicare & Medicaid Services.";
21 (4) by amending subsection (g)(5) to read as
22 follows:
23 "(5) FAILURE TO REPORT OR DISCLOSE INFOR-
24 MATION.—

1 "(A) REPORTING.—Any person who is re-
2 quired, but fails, to meet a reporting require-
3 ment of paragraphs (1) and (2)(A) of sub-
4 section (f) is subject to a civil money penalty of
5 not more than $10,000 for each day for which
6 reporting is required to have been made.
7 "(B) DISCLOSURE.—Any physician who is
8 required, but fails, to meet a disclosure require-
9 ment of subsection (f)(2)(B) or a hospital that
10 is required, but fails, to meet a disclosure re-
11 quirement of subsection (f)(2)(C) is subject to
12 a civil money penalty of not more than $10,000
13 for each case in which disclosure is required to
14 have been made.
15 "(C) APPLICATION.—The provisions of
16 section 1128A (other than the first sentence of
17 subsection (a) and other than subsection (b))
18 shall apply to a civil money penalty under sub-
19 paragraphs (A) and (B) in the same manner as
20 such provisions apply to a penalty or proceeding
21 under section 1128A(a)."; and
22 (5) by adding at the end the following new sub-
23 section:

1 "(i) REQUIREMENTS TO QUALIFY FOR RURAL PRO-
2 VIDER AND HOSPITAL OWNERSHIP EXCEPTIONS TO
3 SELF-REFERRAL PROHIBITION.—
4 "(1) REQUIREMENTS DESCRIBED.—For pur-
5 poses of subsection (d)(3)(D), the requirements de-
6 scribed in this paragraph are as follows:
7 "(A) PROVIDER AGREEMENT.—The hos-
8 pital had—
9 "(i) physician ownership or invest-
10 ment on January 1, 2009; and
11 "(ii) a provider agreement under sec-
12 tion 1866 in effect on such date.
13 "(B) PROHIBITION ON PHYSICIAN OWNER-
14 SHIP OR INVESTMENT.—The percentage of the
15 total value of the ownership or investment in-
16 terests held in the hospital, or in an entity
17 whose assets include the hospital, by physician
18 owners or investors in the aggregate does not
19 exceed such percentage as of the date of enact-
20 ment of this subsection.
21 "(C) PROHIBITION ON EXPANSION OF FA-
22 CILITY CAPACITY.—Except as provided in para-
23 graph (2), the number of operating rooms, pro-
24 cedure rooms, or beds of the hospital at any
25 time on or after the date of the enactment of

1 this subsection are no greater than the number
2 of operating rooms, procedure rooms, or beds,
3 respectively, as of such date.
4 ''(D) ENSURING BONA FIDE OWNERSHIP
5 AND INVESTMENT.—
6 ''(i) Any ownership or investment in-
7 terests that the hospital offers to a physi-
8 cian are not offered on more favorable
9 terms than the terms offered to a person
10 who is not in a position to refer patients
11 or otherwise generate business for the hos-
12 pital.
13 ''(ii) The hospital (or any investors in
14 the hospital) does not directly or indirectly
15 provide loans or financing for any physi-
16 cian owner or investor in the hospital.
17 ''(iii) The hospital (or any investors in
18 the hospital) does not directly or indirectly
19 guarantee a loan, make a payment toward
20 a loan, or otherwise subsidize a loan, for
21 any physician owner or investor or group
22 of physician owners or investors that is re-
23 lated to acquiring any ownership or invest-
24 ment interest in the hospital.

1 "(iv) Ownership or investment returns
2 are distributed to each owner or investor in
3 the hospital in an amount that is directly
4 proportional to the ownership or invest-
5 ment interest of such owner or investor in
6 the hospital.
7 "(v) The investment interest of the
8 owner or investor is directly proportional
9 to the owner's or investor's capital con-
10 tributions made at the time the ownership
11 or investment interest is obtained.
12 "(vi) Physician owners and investors
13 do not receive, directly or indirectly, any
14 guaranteed receipt of or right to purchase
15 other business interests related to the hos-
16 pital, including the purchase or lease of
17 any property under the control of other
18 owners or investors in the hospital or lo-
19 cated near the premises of the hospital.
20 "(vii) The hospital does not offer a
21 physician owner or investor the oppor-
22 tunity to purchase or lease any property
23 under the control of the hospital or any
24 other owner or investor in the hospital on
25 more favorable terms than the terms of-

1 fered to a person that is not a physician
2 owner or investor.
3 "(viii) The hospital does not condition
4 any physician ownership or investment in-
5 terests either directly or indirectly on the
6 physician owner or investor making or in-
7 fluencing referrals to the hospital or other-
8 wise generating business for the hospital.
9 "(E) PATIENT SAFETY.—In the case of a
10 hospital that does not offer emergency services,
11 the hospital has the capacity to—
12 "(i) provide assessment and initial
13 treatment for medical emergencies; and
14 "(ii) if the hospital lacks additional
15 capabilities required to treat the emergency
16 involved, refer and transfer the patient
17 with the medical emergency to a hospital
18 with the required capability.
19 "(F) LIMITATION ON APPLICATION TO
20 CERTAIN CONVERTED FACILITIES.—The hos-
21 pital was not converted from an ambulatory
22 surgical center to a hospital on or after the date
23 of enactment of this subsection.
24 "(2) EXCEPTION TO PROHIBITION ON EXPAN-
25 SION OF FACILITY CAPACITY.—

1 "(A) PROCESS.—

2 "(i) ESTABLISHMENT.—The Secretary
3 shall establish and implement a process
4 under which a hospital may apply for an
5 exception from the requirement under
6 paragraph (1)(C).

7 "(ii) OPPORTUNITY FOR COMMUNITY
8 INPUT.—The process under clause (i) shall
9 provide persons and entities in the commu-
10 nity in which the hospital applying for an
11 exception is located with the opportunity to
12 provide input with respect to the applica-
13 tion.

14 "(iii) TIMING FOR IMPLEMENTA-
15 TION.—The Secretary shall implement the
16 process under clause (i) on the date that is
17 one month after the promulgation of regu-
18 lations described in clause (iv).

19 "(iv) REGULATIONS.—Not later than
20 the first day of the month beginning 18
21 months after the date of the enactment of
22 this subsection, the Secretary shall promul-
23 gate regulations to carry out the process
24 under clause (i). The Secretary may issue

1 such regulations as interim final regula-
2 tions.
3 "(B) FREQUENCY.—The process described
4 in subparagraph (A) shall permit a hospital to
5 apply for an exception up to once every 2 years.
6 "(C) PERMITTED INCREASE.—
7 "(i) IN GENERAL.—Subject to clause
8 (ii) and subparagraph (D), a hospital
9 granted an exception under the process de-
10 scribed in subparagraph (A) may increase
11 the number of operating rooms, procedure
12 rooms, or beds of the hospital above the
13 baseline number of operating rooms, proce-
14 dure rooms, or beds, respectively, of the
15 hospital (or, if the hospital has been grant-
16 ed a previous exception under this para-
17 graph, above the number of operating
18 rooms, procedure rooms, or beds, respec-
19 tively, of the hospital after the application
20 of the most recent increase under such an
21 exception).
22 "(ii) 100 PERCENT INCREASE LIMITA-
23 TION.—The Secretary shall not permit an
24 increase in the number of operating rooms,
25 procedure rooms, or beds of a hospital

1 under clause (i) to the extent such increase
2 would result in the number of operating
3 rooms, procedure rooms, or beds of the
4 hospital exceeding 200 percent of the base-
5 line number of operating rooms, procedure
6 rooms, or beds of the hospital.

7 "(iii) BASELINE NUMBER OF OPER-
8 ATING ROOMS, PROCEDURE ROOMS, OR
9 BEDS.—In this paragraph, the term 'base-
10 line number of operating rooms, procedure
11 rooms, or beds' means the number of oper-
12 ating rooms, procedure rooms, or beds of a
13 hospital as of the date of enactment of this
14 subsection.

15 "(D) INCREASE LIMITED TO FACILITIES
16 ON THE MAIN CAMPUS OF THE HOSPITAL.—
17 Any increase in the number of operating rooms,
18 procedure rooms, or beds of a hospital pursuant
19 to this paragraph may only occur in facilities on
20 the main campus of the hospital.

21 "(E) CONDITIONS FOR APPROVAL OF AN
22 INCREASE IN FACILITY CAPACITY.—The Sec-
23 retary may grant an exception under the proc-
24 ess described in subparagraph (A) only to a
25 hospital—

1 "(i) that is located in a county in
2 which the percentage increase in the popu-
3 lation during the most recent 5-year period
4 for which data are available is estimated to
5 be at least 150 percent of the percentage
6 increase in the population growth of the
7 State in which the hospital is located dur-
8 ing that period, as estimated by Bureau of
9 the Census and available to the Secretary;
10 "(ii) whose annual percent of total in-
11 patient admissions that represent inpatient
12 admissions under the program under title
13 XIX is estimated to be equal to or greater
14 than the average percent with respect to
15 such admissions for all hospitals located in
16 the county in which the hospital is located;
17 "(iii) that does not discriminate
18 against beneficiaries of Federal health care
19 programs and does not permit physicians
20 practicing at the hospital to discriminate
21 against such beneficiaries;
22 "(iv) that is located in a State in
23 which the average bed capacity in the
24 State is estimated to be less than the na-
25 tional average bed capacity;

1 "(v) that has an average bed occu-
2 pancy rate that is estimated to be greater
3 than the average bed occupancy rate in the
4 State in which the hospital is located; and
5 "(vi) that meets other conditions as
6 determined by the Secretary.
7 "(F) PROCEDURE ROOMS.—In this sub-
8 section, the term 'procedure rooms' includes
9 rooms in which catheterizations, angiographies,
10 angiograms, and endoscopies are furnished, but
11 such term shall not include emergency rooms or
12 departments (except for rooms in which cath-
13 eterizations, angiographies, angiograms, and
14 endoscopies are furnished).
15 "(G) PUBLICATION OF FINAL DECI-
16 SIONS.—Not later than 120 days after receiving
17 a complete application under this paragraph,
18 the Secretary shall publish on the public Inter-
19 net website of the Centers for Medicare & Med-
20 icaid Services the final decision with respect to
21 such application.
22 "(H) LIMITATION ON REVIEW.—There
23 shall be no administrative or judicial review
24 under section 1869, section 1878, or otherwise
25 of the exception process under this paragraph,

1 including the establishment of such process,
2 and any determination made under such proc-
3 ess.
4 ''(3) PHYSICIAN OWNER OR INVESTOR DE-
5 FINED.—For purposes of this subsection and sub-
6 section (f)(2), the term 'physician owner or investor'
7 means a physician (or an immediate family member
8 of such physician) with a direct or an indirect own-
9 ership or investment interest in the hospital.
10 ''(4) PATIENT SAFETY REQUIREMENT.—In the
11 case of a hospital to which the requirements of para-
12 graph (1) apply, insofar as the hospital admits a pa-
13 tient and does not have any physician available on
14 the premises 24 hours per day, 7 days per week, be-
15 fore admitting the patient—
16 ''(A) the hospital shall disclose such fact to
17 the patient; and
18 ''(B) following such disclosure, the hospital
19 shall receive from the patient a signed acknowl-
20 edgment that the patient understands such fact.
21 ''(5) CLARIFICATION.—Nothing in this sub-
22 section shall be construed as preventing the Sec-
23 retary from terminating a hospital's provider agree-
24 ment if the hospital is not in compliance with regu-
25 lations pursuant to section 1866.''.

1 (b) VERIFYING COMPLIANCE.—The Secretary of
2 Health and Human Services shall establish policies and
3 procedures to verify compliance with the requirements de-
4 scribed in subsections (i)(1) and (i)(4) of section 1877 of
5 the Social Security Act, as added by subsection (a)(5).
6 The Secretary may use unannounced site reviews of hos-
7 pitals and audits to verify compliance with such require-
8 ments.
9 (c) IMPLEMENTATION.—
10 (1) FUNDING.—For purposes of carrying out
11 the amendments made by subsection (a) and the
12 provisions of subsection (b), in addition to funds
13 otherwise available, out of any funds in the Treasury
14 not otherwise appropriated there are appropriated to
15 the Secretary of Health and Human Services for the
16 Centers for Medicare & Medicaid Services Program
17 Management Account $5,000,000 for each fiscal
18 year beginning with fiscal year 2010. Amounts ap-
19 propriated under this paragraph for a fiscal year
20 shall be available until expended.
21 (2) ADMINISTRATION.—Chapter 35 of title 44,
22 United States Code, shall not apply to the amend-
23 ments made by subsection (a) and the provisions of
24 subsection (b).

1 **SEC. 1157. INSTITUTE OF MEDICINE STUDY OF GEO-**
2 **GRAPHIC ADJUSTMENT FACTORS UNDER**
3 **MEDICARE.**

4 (a) IN GENERAL.—The Secretary of Health and
5 Human Services shall enter into a contract with the Insti-
6 tute of Medicine of the National Academy of Science to
7 conduct a comprehensive empirical study, and provide rec-
8 ommendations as appropriate, on the accuracy of the geo-
9 graphic adjustment factors established under sections
10 1848(e) and 1886(d)(3)(E) of the Social Security Act (42
11 U.S.C. 1395w–4(e), 11395ww(d)(3)).

12 (b) MATTERS INCLUDED.—Such study shall include
13 an evaluation and assessment of the following with respect
14 to such adjustment factors:

15 (1) Empirical validity of the adjustment factors.

16 (2) Methodology used to determine the adjust-
17 ment factors.

18 (3) Measures used for the adjustment factors,
19 taking into account—

20 (A) timeliness of data and frequency of re-
21 visions to such data;

22 (B) sources of data and the degree to
23 which such data are representative of costs; and

24 (C) operational costs of providers who par-
25 ticipate in Medicare.

1 (c) EVALUATION.—Such study shall, within the con-
2 text of the United States health care marketplace, evalu-
3 ate and consider the following:
4 (1) The effect of the adjustment factors on the
5 level and distribution of the health care workforce
6 and resources, including—
7 (A) recruitment and retention that takes
8 into account workforce mobility between urban
9 and rural areas;
10 (B) ability of hospitals and other facilities
11 to maintain an adequate and skilled workforce;
12 and
13 (C) patient access to providers and needed
14 medical technologies.
15 (2) The effect of the adjustment factors on pop-
16 ulation health and quality of care.
17 (3) The effect of the adjustment factors on the
18 ability of providers to furnish efficient, high value
19 care.
20 (d) REPORT.—The contract under subsection (a)
21 shall provide for the Institute of Medicine to submit, not
22 later than one year after the date of the enactment of this
23 Act, to the Secretary and the Congress a report containing
24 results and recommendations of the study conducted
25 under this section.

1 (e) FUNDING.—There are authorized to be appro-
2 priated to carry out this section such sums as may be nec-
3 essary.

4 **SEC. 1158. REVISION OF MEDICARE PAYMENT SYSTEMS TO**
5 **ADDRESS GEOGRAPHIC INEQUITIES.**

6 (a) REVISION OF MEDICARE PAYMENT SYSTEMS.—
7 Taking into account the recommendations described in the
8 report under section 1157, and notwithstanding the geo-
9 graphic adjustments that would otherwise apply under sec-
10 tion 1848(e) and section 1886(d)(3)(E) of the Social Se-
11 curity Act ((42 U.S.C. 1395w-4, 1395ww(d)), the Sec-
12 retary of Health and Human Services shall include in pro-
13 posed rules applicable to the rulemaking cycle for payment
14 systems for physicians' services and inpatient hospital
15 services under sections 1848 and section 1886(d) of such
16 Act, respectively, proposals (as the Secretary determines
17 to be appropriate) to revise the geographic adjustment fac-
18 tors used in such systems. Such proposals' rules shall be
19 contained in the next rulemaking cycle following the sub-
20 mission to the Secretary of the report described in section
21 1157.

22 (b) PAYMENT ADJUSTMENTS.—
23 (1) FUNDING FOR IMPROVEMENTS.—The Sec-
24 retary shall use funds as provided under subsection
25 (c) in making changes to the geographic adjustment

factors pursuant to subsection (a). In making such changes to such geographic adjustment factors, the Secretary shall ensure that the estimated increased expenditures resulting from such changes does not exceed the amounts provided under subsection (c).

(2) ENSURING FAIRNESS.—In carrying out this subsection, the Secretary shall not reduce the geographic adjustment below the factor that applied for such payment system in the payment year before such changes.

(c) FUNDING.—Amounts in the Medicare Improvement Fund under section 1898, as amended by section 1146, shall be available to the Secretary to make changes to the geographic adjustments factors as described in subsections (a) and (b) with respect to services furnished before January 1, 2014. No more than one-half of such amounts shall be available with respect to services furnished in any one payment year.

SEC. 1159. INSTITUTE OF MEDICINE STUDY OF GEOGRAPHIC VARIATION IN HEALTH CARE SPENDING AND PROMOTING HIGH-VALUE HEALTH CARE.

(a) IN GENERAL.—The Secretary of Health and Human Services shall enter into an agreement with the Institutes of Medicine of the National Academies (referred

1 to in this section as the ''Institute'') to conduct a study
2 on geographic variation in per capita health care spending
3 among both the Medicare and privately insured popu-
4 lations. Such study shall include each of the following:
5 (1) An evaluation of the extent and range of
6 such variation using various units of geographic
7 measurement.
8 (2) The extent to which geographic variation
9 can be attributed to differences in input prices, prac-
10 tice patterns, access to medical services, supply of
11 medical services, socio-economic factors, and pro-
12 vider organizational models.
13 (3) The extent to which variations in spending
14 are correlated with patient access to care, distribu-
15 tion of health care resources, and consensus-based
16 measures of health care quality.
17 (4) The extent to which variation can be attrib-
18 uted to physician and practitioner discretion in mak-
19 ing treatment decisions, and the degree to which dis-
20 cretionary treatment decisions are made that could
21 be characterized as different from the best available
22 medical evidence.
23 (5) An assessment of the degree to which vari-
24 ation cannot be explained by empirical evidence.

1 (6) Other factors the Institute deems appro-
2 priate.
3 (b) RECOMMENDATIONS.—Taking into account the
4 findings under subsection (a), the Institute shall rec-
5 ommend strategies for addressing variation in per capita
6 spending by promoting high-value care (as defined in sub-
7 section (e)). In making such recommendations, the Insti-
8 tute shall consider each of the following:
9 (1) Measurement and reporting on quality and
10 population health.
11 (2) Reducing fragmented and duplicative care.
12 (3) Promoting the practice of evidence-based
13 medicine.
14 (4) Empowering patients to make value-based
15 care decisions.
16 (5) Leveraging the use of health information
17 technology.
18 (6) The role of financial and other incentives.
19 (7) Other topics the Institute deems appro-
20 priate.
21 (c) SPECIFIC CONSIDERATIONS.—In making the rec-
22 ommendations under subsection (b), the Institute shall
23 specifically address whether payment systems under title
24 XVIII of the Social Security Act for physicians and hos-
25 pitals should be further modified to incentivize high-value

1 care. In so doing, the Institute shall consider the adoption
2 of a value index based on a composite of appropriate meas-
3 ures of quality and cost that would adjust provider pay-
4 ments on a regional or provider-level basis. If the Institute
5 finds that application of such a value index would signifi-
6 cantly incentivize providers to furnish high-value care, it
7 shall make specific recommendations on how such an
8 index would be designed and implemented. In so doing,
9 it should identify specific measures of quality and cost ap-
10 propriate for use in such an index, and include a thorough
11 analysis (including on a geographic basis) of how pay-
12 ments and spending under such title would be affected by
13 such an index.
14 (d) REPORT.— Not later than three years after the
15 date of the enactment of this Act, the Institute shall sub-
16 mit to Congress a report containing findings and rec-
17 ommendations of the study conducted under this section.
18 (e) HIGH-VALUE CARE DEFINED.—For purposes of
19 this section, the term ''high-value care'' means the effi-
20 cient delivery of high quality, evidence-based, patient-cen-
21 tered care.
22 (f) AUTHORIZATION OF APPROPRIATIONS.—There is
23 authorized to be appropriated such sums as are necessary
24 to carry out this section. Such sums are authorized to re-
25 main available until expended.

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—

1 "(i) 2/3 of the applicable amount (as
2 defined in subsection (k)) for the area and
3 year; and
4 "(ii) 1/3 of the amount specified in
5 paragraph (2) for the area and year;
6 "(B) for 2012 the sum of—
7 "(i) 1/3 of the applicable amount for
8 the area and year; and
9 "(ii) 2/3 of the amount specified in
10 paragraph (2) for the area and year; and
11 "(C) for a subsequent year the amount
12 specified in paragraph (2) for the area and
13 year.
14 "(2) SPECIFIED AMOUNT.—The amount speci-
15 fied in this paragraph for an area and year is the
16 amount specified in subsection (c)(1)(D)(i) for the
17 area and year adjusted (in a manner specified by the
18 Secretary) to take into account the phase-out in the
19 indirect costs of medical education from capitation
20 rates described in subsection (k)(4).
21 "(3) FEE-FOR-SERVICE PAYMENT FLOOR.—In
22 no case shall the blended benchmark amount for an
23 area and year be less than the amount specified in
24 paragraph (2).

1 "(4) EXCEPTION FOR PACE PLANS.—This sub-
2 section shall not apply to payments to a PACE pro-
3 gram under section 1894.".

4 **SEC. 1162. QUALITY BONUS PAYMENTS.**

5 (a) IN GENERAL.—Section 1853 of the Social Secu-
6 rity Act (42 U.S.C. 1395w-23), as amended by section
7 1161, is amended—

8 (1) in subsection (j), by inserting "subject to
9 subsection (o)," after "For purposes of this part";
10 and

11 (2) by adding at the end the following new sub-
12 section:

13 "(o) QUALITY BASED PAYMENT ADJUSTMENT.—

14 "(1) IN GENERAL.—In the case of a qualifying
15 plan in a qualifying county with respect to a year
16 beginning with 2011, the blended benchmark
17 amount under subsection (n)(1) shall be increased—

18 "(A) for 2011, by 2.6 percent;

19 "(B) for 2012, by 5.3 percent; and

20 "(C) for a subsequent year, by 8.0 percent.

21 "(2) QUALIFYING PLAN AND QUALIFYING
22 COUNTY DEFINED.—For purposes of this subsection:

23 "(A) QUALIFYING PLAN.—The term 'quali-
24 fying plan' means, for a year and subject to
25 paragraph (4), a plan that, in a preceding year

1 specified by the Secretary, had a quality rank-
2 ing (based on the quality ranking system estab-
3 lished by the Centers for Medicare & Medicaid
4 Services for Medicare Advantage plans) of 4
5 stars or higher.
6 "(B) QUALIFYING COUNTY.—The term
7 'qualifying county'means, for a year, a county—
8 "(i) that ranked within the lowest
9 quartile of counties in the amount specified
10 in subsection (n)(2) for the year specified
11 by the Secretary under subparagraph (A);
12 and
13 "(ii) for which, as of June of such
14 specified year, of the Medicare Advantage
15 eligible individuals residing in the county—
16 "(I) at least 50 percent of such
17 individuals were enrolled in Medicare
18 Advantage plans; and
19 "(II) of the residents so enrolled
20 at least 50 percent of such individuals
21 were enrolled in such plans with a
22 quality ranking (based on the quality
23 ranking system established by the
24 Centers for Medicare & Medicaid

Services for Medicare Advantage plans) of 4 stars or higher.

"(3) NOTIFICATION.—The Secretary, in the annual announcement required under subsection (b)(1)(B) in 2010 and each succeeding year, shall notify the Medicare Advantage organization that is offering a qualifying plan in a qualifying county of such identification for the year. The Secretary shall provide for publication on the website for the Medicare program of the information described in the previous sentence.

"(4) AUTHORITY TO DISQUALIFY DEFICIENT PLANS.—The Secretary may determine that a Medicare Advantage plan is not a qualifying plan if the Secretary has identified deficiencies in the plan's compliance with rules for Medicare Advantage plans under this part.".

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)—

1 (A) by inserting ''periodically'' before ''con-
2 duct an analysis'';
3 (B) by inserting ''on a timely basis'' after
4 ''are incorporated''; and
5 (C) by striking ''only for 2008, 2009, and
6 2010'' and inserting ''for 2008 and subsequent
7 years''.

8 **SEC. 1164. SIMPLIFICATION OF ANNUAL BENEFICIARY**
9 **ELECTION PERIODS.**

10 (a) 2 WEEK PROCESSING PERIOD FOR ANNUAL EN-
11 ROLLMENT PERIOD (AEP).—Paragraph (3)(B) of section
12 1851(e) of the Social Security Act (42 U.S.C. 1395w–
13 21(e)) is amended—
14 (1) by striking ''and'' at the end of clause (iii);
15 (2) in clause (iv)—
16 (A) by striking ''and succeeding years''
17 and inserting '', 2008, 2009, and 2010''; and
18 (B) by striking the period at the end and
19 inserting ''; and''; and
20 (3) by adding at the end the following new
21 clause:
22 ''(v) with respect to 2011 and suc-
23 ceeding years, the period beginning on No-
24 vember 1 and ending on December 15 of
25 the year before such year.''.

1 (b) ELIMINATION OF 3-MONTH ADDITIONAL OPEN
2 ENROLLMENT PERIOD (OEP).—Effective for plan years
3 beginning with 2011, paragraph (2) of such section is
4 amended by striking subparagraph (C).

5 **SEC. 1165. EXTENSION OF REASONABLE COST CONTRACTS.**

6 Section 1876(h)(5)(C) of the Social Security Act (42
7 U.S.C. 1395mm(h)(5)(C)) is amended—
8 (1) in clause (ii), by striking "January 1,
9 2010" and inserting "January 1, 2012"; and
10 (2) in clause (iii), by striking "the service area
11 for the year" and inserting "the portion of the
12 plan's service area for the year that is within the
13 service area of a reasonable cost reimbursement con-
14 tract".

15 **SEC. 1166. LIMITATION OF WAIVER AUTHORITY FOR EM-**
16 **PLOYER GROUP PLANS.**

17 (a) IN GENERAL.—The first sentence of paragraph
18 (2) of section 1857(i) of the Social Security Act (42
19 U.S.C. 1395w–27(i)) is amended by inserting before the
20 period at the end the following: ", but only if 90 percent
21 of the Medicare Advantage eligible individuals enrolled
22 under such plan reside in a county in which the MA orga-
23 nization offers an MA local plan".
24 (b) EFFECTIVE DATE.—The amendment made by
25 subsection (a) shall apply for plan years beginning on or

1 after January 1, 2011, and shall not apply to plans which
2 were in effect as of December 31, 2010.

3 **SEC. 1167. IMPROVING RISK ADJUSTMENT FOR PAYMENTS.**

4 (a) REPORT TO CONGRESS.—Not later than 1 year
5 after the date of the enactment of this Act, the Secretary
6 of Health and Human Services shall submit to Congress
7 a report that evaluates the adequacy of the risk adjust-
8 ment system under section 1853(a)(1)(C) of the Social Se-
9 curity Act (42 U.S.C. 1395–23(a)(1)(C)) in predicting
10 costs for beneficiaries with chronic or co-morbid condi-
11 tions, beneficiaries dually-eligible for Medicare and Med-
12 icaid, and non-Medicaid eligible low-income beneficiaries;
13 and the need and feasibility of including further grada-
14 tions of diseases or conditions and multiple years of bene-
15 ficiary data.

16 (b) IMPROVEMENTS TO RISK ADJUSTMENT.—Not
17 later than January 1, 2012, the Secretary shall implement
18 necessary improvements to the risk adjustment system
19 under section 1853(a)(1)(C) of the Social Security Act (42
20 U.S.C. 1395–23(a)(1)(C)), taking into account the evalua-
21 tion under subsection (a).

1 **SEC. 1168. ELIMINATION OF MA REGIONAL PLAN STA-**
2 **BILIZATION FUND.**
3 (a) IN GENERAL.—Section 1858 of the Social Secu-
4 rity Act (42 U.S.C. 1395w–27a) is amended by striking
5 subsection (e).
6 (b) TRANSITION.—Any amount contained in the MA
7 Regional Plan Stabilization Fund as of the date of the
8 enactment of this Act shall be transferred to the Federal
9 Supplementary Medical Insurance Trust Fund.
10 **PART 2—BENEFICIARY PROTECTIONS AND ANTI-**
11 **FRAUD**
12 **SEC. 1171. LIMITATION ON COST-SHARING FOR INDIVIDUAL**
13 **HEALTH SERVICES.**
14 (a) IN GENERAL.—Section 1852(a)(1) of the Social
15 Security Act (42 U.S.C. 1395w–22(a)(1)) is amended—
16 (1) in subparagraph (A), by inserting before the
17 period at the end the following: ''with cost-sharing
18 that is no greater (and may be less) than the cost-
19 sharing that would otherwise be imposed under such
20 program option'';
21 (2) in subparagraph (B)(i), by striking ''or an
22 actuarially equivalent level of cost-sharing as deter-
23 mined in this part''; and
24 (3) by amending clause (ii) of subparagraph
25 (B) to read as follows:

1 "(ii) PERMITTING USE OF FLAT CO-
2 PAYMENT OR PER DIEM RATE.—Nothing in
3 clause (i) shall be construed as prohibiting
4 a Medicare Advantage plan from using a
5 flat copayment or per diem rate, in lieu of
6 the cost-sharing that would be imposed
7 under part A or B, so long as the amount
8 of the cost-sharing imposed does not ex-
9 ceed the amount of the cost-sharing that
10 would be imposed under the respective part
11 if the individual were not enrolled in a plan
12 under this part.".
13 (b) LIMITATION FOR DUAL ELIGIBLES AND QUALI-
14 FIED MEDICARE BENEFICIARIES.—Section 1852(a) of
15 such Act is amended by adding at the end the following
16 new paragraph:
17 "(7) LIMITATION ON COST-SHARING FOR DUAL
18 ELIGIBLES AND QUALIFIED MEDICARE BENE-
19 FICIARIES.—In the case of a individual who is a full-
20 benefit dual eligible individual (as defined in section
21 1935(c)(6)) or a qualified medicare beneficiary (as
22 defined in section 1905(p)(1)) who is enrolled in a
23 Medicare Advantage plan, the plan may not impose
24 cost-sharing that exceeds the amount of cost-sharing
25 that would be permitted with respect to the indi-

1 vidual under this title and title XIX if the individual
2 were not enrolled with such plan.''.
3 (c) EFFECTIVE DATES.—
4 (1) The amendments made by subsection (a)
5 shall apply to plan years beginning on or after Janu-
6 ary 1, 2011.
7 (2) The amendments made by subsection (b)
8 shall apply to plan years beginning on or after Janu-
9 ary 1, 2011.
10 **SEC. 1172. CONTINUOUS OPEN ENROLLMENT FOR ENROLL-**
11 **EES IN PLANS WITH ENROLLMENT SUSPEN-**
12 **SION.**
13 Section 1851(e)(4) of the Social Security Act (42
14 U.S.C. 1395w(e)(4)) is amended—
15 (1) in subparagraph (C), by striking at the end
16 ''or'';
17 (2) in subparagraph (D)—
18 (A) by inserting '', taking into account the
19 health or well-being of the individual'' before
20 the period; and
21 (B) by redesignating such subparagraph as
22 subparagraph (E); and
23 (3) by inserting after subparagraph (C) the fol-
24 lowing new subparagraph:

1 "(D)) the individual is enrolled in an MA
2 plan and enrollment in the plan is suspended
3 under paragraph (2)(B) or (3)(C) of section
4 1857(g) because of a failure of the plan to meet
5 applicable requirements; or".

6 **SEC. 1173. INFORMATION FOR BENEFICIARIES ON MA PLAN**
7 **ADMINISTRATIVE COSTS.**

8 (a) DISCLOSURE OF MEDICAL LOSS RATIOS AND
9 OTHER EXPENSE DATA.—Section 1851 of the Social Se-
10 curity Act (42 U.S.C. 1395w–21), as previously amended
11 by this subtitle, is amended by adding at the end the fol-
12 lowing new subsection:

13 "(p) PUBLICATION OF MEDICAL LOSS RATIOS AND
14 OTHER COST-RELATED INFORMATION.—

15 "(1) IN GENERAL.—The Secretary shall pub-
16 lish, not later than November 1 of each year (begin-
17 ning with 2011), for each MA plan contract, the
18 medical loss ratio of the plan in the previous year.

19 "(2) SUBMISSION OF DATA.—

20 "(A) IN GENERAL.—Each MA organization
21 shall submit to the Secretary, in a form and
22 manner specified by the Secretary, data nec-
23 essary for the Secretary to publish the medical
24 loss ratio on a timely basis.

1 "(B) DATA FOR 2010 AND 2011.—The data
2 submitted under subparagraph (A) for 2010
3 and for 2011 shall be consistent in content with
4 the data reported as part of the MA plan bid
5 in June 2009 for 2010.
6 "(C) USE OF STANDARDIZED ELEMENTS
7 AND DEFINITIONS.—The data to be submitted
8 under subparagraph (A) relating to medical loss
9 ratio for a year, beginning with 2012, shall be
10 submitted based on the standardized elements
11 and definitions developed under paragraph (3).
12 "(3) DEVELOPMENT OF DATA REPORTING
13 STANDARDS.—
14 "(A) IN GENERAL.—The Secretary shall
15 develop and implement standardized data ele-
16 ments and definitions for reporting under this
17 subsection, for contract years beginning with
18 2012, of data necessary for the calculation of
19 the medical loss ratio for MA plans. Not later
20 than December 31, 2010, the Secretary shall
21 publish a report describing the elements and
22 definitions so developed.
23 "(B) CONSULTATION.—The Secretary
24 shall consult with the Health Choices Commis-
25 sioner, representatives of MA organizations, ex-

1 perts on health plan accounting systems, and
2 representatives of the National Association of
3 Insurance Commissioners, in the development
4 of such data elements and definitions.
5 ''(4) MEDICAL LOSS RATIO TO BE DEFINED.—
6 For purposes of this part, the term 'medical loss
7 ratio' has the meaning given such term by the Sec-
8 retary, taking into account the meaning given such
9 term by the Health Choices Commissioner under
10 section 116 of the America's Affordable Health
11 Choices Act of 2009.''.
12 (b) MINIMUM MEDICAL LOSS RATIO.—Section
13 1857(e) of the Social Security Act (42 U.S.C. 1395w–
14 27(e)) is amended by adding at the end the following new
15 paragraph:
16 ''(4) REQUIREMENT FOR MINIMUM MEDICAL
17 LOSS RATIO.—If the Secretary determines for a con-
18 tract year (beginning with 2014) that an MA plan
19 has failed to have a medical loss ratio (as defined in
20 section 1851(p)(4)) of at least .85—
21 ''(A) the Secretary shall require the Medi-
22 care Advantage organization offering the plan
23 to give enrollees a rebate (in the second suc-
24 ceeding contract year) of premiums under this
25 part (or part B or part D, if applicable) by

1 such amount as would provide for a benefits
2 ratio of at least .85;
3 ''(B) for 3 consecutive contract years, the
4 Secretary shall not permit the enrollment of
5 new enrollees under the plan for coverage dur-
6 ing the second succeeding contract year; and
7 ''(C) the Secretary shall terminate the plan
8 contract if the plan fails to have such a medical
9 loss ratio for 5 consecutive contract years.''.

10 **SEC. 1174. STRENGTHENING AUDIT AUTHORITY.**

11 (a) FOR PART C PAYMENTS RISK ADJUSTMENT.—
12 Section 1857(d)(1) of the Social Security Act (42 U.S.C.
13 1395w–27(d)(1)) is amended by inserting after ''section
14 1858(c))'' the following: '', and data submitted with re-
15 spect to risk adjustment under section 1853(a)(3)''.
16 (b) ENFORCEMENT OF AUDITS AND DEFI-
17 CIENCIES.—
18 (1) IN GENERAL.—Section 1857(e) of such Act,
19 as amended by section 1173, is amended by adding
20 at the end the following new paragraph:
21 ''(5) ENFORCEMENT OF AUDITS AND DEFI-
22 CIENCIES.—
23 ''(A) INFORMATION IN CONTRACT.—The
24 Secretary shall require that each contract with
25 an MA organization under this section shall in-

1 clude terms that inform the organization of the
2 provisions in subsection (d).
3 ‘‘(B) ENFORCEMENT AUTHORITY.—The
4 Secretary is authorized, in connection with con-
5 ducting audits and other activities under sub-
6 section (d), to take such actions, including pur-
7 suit of financial recoveries, necessary to address
8 deficiencies identified in such audits or other
9 activities.’’.
10 (2) APPLICATION UNDER PART D.—For provi-
11 sion applying the amendment made by paragraph
12 (1) to prescription drug plans under part D, see sec-
13 tion 1860D–12(b)(3)(D) of the Social Security Act.
14 (c) EFFECTIVE DATE.—The amendments made by
15 this section shall take effect on the date of the enactment
16 of this Act and shall apply to audits and activities con-
17 ducted for contract years beginning on or after January
18 1, 2011.
19 **SEC. 1175. AUTHORITY TO DENY PLAN BIDS.**
20 (a) IN GENERAL.—Section 1854(a)(5) of the Social
21 Security Act (42 U.S.C. 1395w–24(a)(5)) is amended by
22 adding at the end the following new subparagraph:
23 ‘‘(C) REJECTION OF BIDS.—Nothing in
24 this section shall be construed as requiring the

1 Secretary to accept any or every bid by an MA
2 organization under this subsection.''.
3 (b) APPLICATION UNDER PART D.—Section 1860D–
4 11(d) of such Act (42 U.S.C. 1395w–111(d)) is amended
5 by adding at the end the following new paragraph:
6 ''(3) REJECTION OF BIDS.—Paragraph (5)(C)
7 of section 1854(a) shall apply with respect to bids
8 under this section in the same manner as it applies
9 to bids by an MA organization under such section.''.
10 (c) EFFECTIVE DATE.—The amendments made by
11 this section shall apply to bids for contract years begin-
12 ning on or after January 1, 2011.

13 **PART 3—TREATMENT OF SPECIAL NEEDS PLANS**

14 **SEC. 1176. LIMITATION ON ENROLLMENT OUTSIDE OPEN**
15 **ENROLLMENT PERIOD OF INDIVIDUALS INTO**
16 **CHRONIC CARE SPECIALIZED MA PLANS FOR**
17 **SPECIAL NEEDS INDIVIDUALS.**

18 Section 1859(f)(4) of the Social Security Act (42
19 U.S.C. 1395w–28(f)(4)) is amended by adding at the end
20 the following new subparagraph:
21 ''(C) The plan does not enroll an individual
22 on or after January 1, 2011, other than during
23 an annual, coordinated open enrollment period
24 or when at the time of the diagnosis of the dis-
25 ease or condition that qualifies the individual as

1 an individual described in subsection
2 (b)(6)(B)(iii).''.

3 **SEC. 1177. EXTENSION OF AUTHORITY OF SPECIAL NEEDS**
4 **PLANS TO RESTRICT ENROLLMENT.**

5 (a) IN GENERAL.—Section 1859(f)(1) of the Social
6 Security Act (42 U.S.C. 1395w–28(f)(1)) is amended by
7 striking ''January 1, 2011'' and inserting ''January 1,
8 2013 (or January 1, 2016, in the case of a plan described
9 in section 1177(b)(1) of the America's Affordable Health
10 Choices Act of 2009)''.

11 (b) GRANDFATHERING OF CERTAIN PLANS.—

12 (1) PLANS DESCRIBED.—For purposes of sec-
13 tion 1859(f)(1) of the Social Security Act (42
14 U.S.C. 1395w–28(f)(1)), a plan described in this
15 paragraph is a plan that had a contract with a State
16 that had a State program to operate an integrated
17 Medicaid-Medicare program that had been approved
18 by the Centers for Medicare & Medicaid Services as
19 of January 1, 2004.

20 (2) ANALYSIS; REPORT.—The Secretary of
21 Health and Human Services shall provide, through
22 a contract with an independent health services eval-
23 uation organization, for an analysis of the plans de-
24 scribed in paragraph (1) with regard to the impact
25 of such plans on cost, quality of care, patient satis-

1 faction, and other subjects as specified by the Sec-
2 retary. Not later than December 31, 2011, the Sec-
3 retary shall submit to Congress a report on such
4 analysis and shall include in such report such rec-
5 ommendations with regard to the treatment of such
6 plans as the Secretary deems appropriate.

7 Subtitle E—Improvements to 8 Medicare Part D

9 SEC. 1181. ELIMINATION OF COVERAGE GAP.

10 (a) IN GENERAL.—Section 1860D–2(b) of such Act
11 (42 U.S.C. 1395w–102(b)) is amended—
12 (1) in paragraph (3)(A), by striking ''paragraph
13 (4)'' and inserting ''paragraphs (4) and (7)'';
14 (2) in paragraph (4)(B)(i), by inserting ''sub-
15 ject to paragraph (7)'' after ''purposes of this part'';
16 and
17 (3) by adding at the end the following new
18 paragraph:
19 ''(7) PHASED-IN ELIMINATION OF COVERAGE
20 GAP.—
21 ''(A) IN GENERAL.—For each year begin-
22 ning with 2011, the Secretary shall consistent
23 with this paragraph progressively increase the
24 initial coverage limit (described in subsection
25 (b)(3)) and decrease the annual out-of-pocket

1 threshold from the amounts otherwise computed
2 until there is a continuation of coverage from
3 the initial coverage limit for expenditures in-
4 curred through the total amount of expendi-
5 tures at which benefits are available under
6 paragraph (4).

7 ‘‘(B) INCREASE IN INITIAL COVERAGE
8 LIMIT.—For a year beginning with 2011, the
9 initial coverage limit otherwise computed with-
10 out regard to this paragraph shall be increased
11 by ½ of the cumulative phase-in percentage (as
12 defined in subparagraph (D)(ii) for the year)
13 times the out-of-pocket gap amount (as defined
14 in subparagraph (E)) for the year.

15 ‘‘(C) DECREASE IN ANNUAL OUT-OF-POCK-
16 ET THRESHOLD.—For a year beginning with
17 2011, the annual out-of-pocket threshold other-
18 wise computed without regard to this paragraph
19 shall be decreased by ½ of the cumulative
20 phase-in percentage of the out-of-pocket gap
21 amount for the year multiplied by 1.75.

22 ‘‘(D) PHASE–IN.—For purposes of this
23 paragraph:

1 "(i) ANNUAL PHASE-IN PERCENT-
2 AGE.—The term 'annual phase-in percent-
3 age' means—
4 "(I) for 2011, 13 percent;
5 "(II) for 2012, 2013, 2014, and
6 2015, 5 percent;
7 "(III) for 2016 through 2018,
8 7.5 percent; and
9 "(IV) for 2019 and each subse-
10 quent year, 10 percent.
11 "(ii) CUMULATIVE PHASE-IN PER-
12 CENTAGE.—The term 'cumulative phase-in
13 percentage' means for a year the sum of
14 the annual phase-in percentage for the
15 year and the annual phase-in percentages
16 for each previous year beginning with
17 2011, but in no case more than 100 per-
18 cent.
19 "(E) OUT-OF-POCKET GAP AMOUNT.—For
20 purposes of this paragraph, the term 'out-of-
21 pocket gap amount' means for a year the
22 amount by which—
23 "(i) the annual out-of-pocket thresh-
24 old specified in paragraph (4)(B) for the

1 year (as determined as if this paragraph
2 did not apply), exceeds
3 ‘‘(ii) the sum of—
4 ‘‘(I) the annual deductible under
5 paragraph (1) for the year; and
6 ‘‘(II) 1⁄4 of the amount by which
7 the initial coverage limit under para-
8 graph (3) for the year (as determined
9 as if this paragraph did not apply) ex-
10 ceeds such annual deductible.’’.
11 (b) REQUIRING DRUG MANUFACTURERS TO PROVIDE
12 DRUG REBATES FOR FULL-BENEFIT DUAL ELIGIBLES.—
13 (1) IN GENERAL.—Section 1860D–2 of the So-
14 cial Security Act (42 U.S.C. 1396r–8) is amended—
15 (A) in subsection (e)(1), in the matter be-
16 fore subparagraph (A), by inserting ‘‘and sub-
17 section (f)’’ after ‘‘this subsection’’; and
18 (B) by adding at the end the following new
19 subsection:
20 ‘‘(f) PRESCRIPTION DRUG REBATE AGREEMENT FOR
21 FULL-BENEFIT DUAL ELIGIBLE INDIVIDUALS.—
22 ‘‘(1) IN GENERAL.—In this part, the term ‘cov-
23 ered part D drug’ does not include any drug or bio-
24 logic that is manufactured by a manufacturer that

1 has not entered into and have in effect a rebate
2 agreement described in paragraph (2).
3 ‘‘(2) REBATE AGREEMENT.—A rebate agree-
4 ment under this subsection shall require the manu-
5 facturer to provide to the Secretary a rebate for
6 each rebate period (as defined in paragraph (6)(B))
7 ending after December 31, 2010, in the amount
8 specified in paragraph (3) for any covered part D
9 drug of the manufacturer dispensed after December
10 31, 2010, to any full-benefit dual eligible individual
11 (as defined in paragraph (6)(A)) for which payment
12 was made by a PDP sponsor under part D or a MA
13 organization under part C for such period. Such re-
14 bate shall be paid by the manufacturer to the Sec-
15 retary not later than 30 days after the date of re-
16 ceipt of the information described in section 1860D–
17 12(b)(7), including as such section is applied under
18 section 1857(f)(3).
19 ‘‘(3) REBATE FOR FULL-BENEFIT DUAL ELIGI-
20 BLE MEDICARE DRUG PLAN ENROLLEES.—
21 ‘‘(A) IN GENERAL.—The amount of the re-
22 bate specified under this paragraph for a manu-
23 facturer for a rebate period, with respect to
24 each dosage form and strength of any covered
25 part D drug provided by such manufacturer

1 and dispensed to a full-benefit dual eligible indi-
2 vidual, shall be equal to the product of—
3 "(i) the total number of units of such
4 dosage form and strength of the drug so
5 provided and dispensed for which payment
6 was made by a PDP sponsor under part D
7 or a MA organization under part C for the
8 rebate period (as reported under section
9 1860D–12(b)(7), including as such section
10 is applied under section 1857(f)(3)); and
11 "(ii) the amount (if any) by which—
12 "(I) the Medicaid rebate amount
13 (as defined in subparagraph (B)) for
14 such form, strength, and period, ex-
15 ceeds
16 "(II) the average Medicare drug
17 program full-benefit dual eligible re-
18 bate amount (as defined in subpara-
19 graph (C)) for such form, strength,
20 and period.
21 "(B) MEDICAID REBATE AMOUNT.—For
22 purposes of this paragraph, the term 'Medicaid
23 rebate amount' means, with respect to each
24 dosage form and strength of a covered part D

1 drug provided by the manufacturer for a rebate
2 period—
3 "(i) in the case of a single source
4 drug or an innovator multiple source drug,
5 the amount specified in paragraph
6 (1)(A)(ii) of section 1927(b) plus the
7 amount, if any, specified in paragraph
8 (2)(A)(ii) of such section, for such form,
9 strength, and period; or
10 "(ii) in the case of any other covered
11 outpatient drug, the amount specified in
12 paragraph (3)(A)(i) of such section for
13 such form, strength, and period.
14 "(C) AVERAGE MEDICARE DRUG PROGRAM
15 FULL-BENEFIT DUAL ELIGIBLE REBATE
16 AMOUNT.—For purposes of this subsection, the
17 term 'average Medicare drug program full-ben-
18 efit dual eligible rebate amount' means, with re-
19 spect to each dosage form and strength of a
20 covered part D drug provided by a manufac-
21 turer for a rebate period, the sum, for all PDP
22 sponsors under part D and MA organizations
23 administering a MA–PD plan under part C,
24 of—

1 "(i) the product, for each such spon-
2 sor or organization, of—
3 "(I) the sum of all rebates, dis-
4 counts, or other price concessions (not
5 taking into account any rebate pro-
6 vided under paragraph (2) for such
7 dosage form and strength of the drug
8 dispensed, calculated on a per-unit
9 basis, but only to the extent that any
10 such rebate, discount, or other price
11 concession applies equally to drugs
12 dispensed to full-benefit dual eligible
13 Medicare drug plan enrollees and
14 drugs dispensed to PDP and MA–PD
15 enrollees who are not full-benefit dual
16 eligible individuals; and
17 "(II) the number of the units of
18 such dosage and strength of the drug
19 dispensed during the rebate period to
20 full-benefit dual eligible individuals
21 enrolled in the prescription drug plans
22 administered by the PDP sponsor or
23 the MA–PD plans administered by the
24 MA–PD organization; divided by

1 "(ii) the total number of units of such
2 dosage and strength of the drug dispensed
3 during the rebate period to full-benefit
4 dual eligible individuals enrolled in all pre-
5 scription drug plans administered by PDP
6 sponsors and all MA–PD plans adminis-
7 tered by MA–PD organizations.

8 "(4) LENGTH OF AGREEMENT.—The provisions
9 of paragraph (4) of section 1927(b) (other than
10 clauses (iv) and (v) of subparagraph (B)) shall apply
11 to rebate agreements under this subsection in the
12 same manner as such paragraph applies to a rebate
13 agreement under such section.

14 "(5) OTHER TERMS AND CONDITIONS.—The
15 Secretary shall establish other terms and conditions
16 of the rebate agreement under this subsection, in-
17 cluding terms and conditions related to compliance,
18 that are consistent with this subsection.

19 "(6) DEFINITIONS.—In this subsection and sec-
20 tion 1860D–12(b)(7):

21 "(A) FULL-BENEFIT DUAL ELIGIBLE INDI-
22 VIDUAL.—The term 'full-benefit dual eligible in-
23 dividual' has the meaning given such term in
24 section 1935(c)(6).

1 "(B) REBATE PERIOD.—The term 'rebate
2 period' has the meaning given such term in sec-
3 tion 1927(k)(8).".
4 (2) REPORTING REQUIREMENT FOR THE DE-
5 TERMINATION AND PAYMENT OF REBATES BY MANU-
6 FACTURES RELATED TO REBATE FOR FULL-BENEFIT
7 DUAL ELIGIBLE MEDICARE DRUG PLAN ENROLL-
8 EES.—
9 (A) REQUIREMENTS FOR PDP SPON-
10 SORS.—Section 1860D–12(b) of the Social Se-
11 curity Act (42 U.S.C. 1395w–112(b)) is amend-
12 ed by adding at the end the following new para-
13 graph:
14 "(7) REPORTING REQUIREMENT FOR THE DE-
15 TERMINATION AND PAYMENT OF REBATES BY MANU-
16 FACTURERS RELATED TO REBATE FOR FULL-BEN-
17 EFIT DUAL ELIGIBLE MEDICARE DRUG PLAN EN-
18 ROLLEES.—
19 "(A) IN GENERAL.—For purposes of the
20 rebate under section 1860D–2(f) for contract
21 years beginning on or after January 1, 2011,
22 each contract entered into with a PDP sponsor
23 under this part with respect to a prescription
24 drug plan shall require that the sponsor comply
25 with subparagraphs (B) and (C).

1 "(B) REPORT FORM AND CONTENTS.—Not
2 later than 60 days after the end of each rebate
3 period (as defined in section 1860D–2(f)(6)(B))
4 within such a contract year to which such sec-
5 tion applies, a PDP sponsor of a prescription
6 drug plan under this part shall report to each
7 manufacturer—
8 "(i) information (by National Drug
9 Code number) on the total number of units
10 of each dosage, form, and strength of each
11 drug of such manufacturer dispensed to
12 full-benefit dual eligible Medicare drug
13 plan enrollees under any prescription drug
14 plan operated by the PDP sponsor during
15 the rebate period;
16 "(ii) information on the price dis-
17 counts, price concessions, and rebates for
18 such drugs for such form, strength, and
19 period;
20 "(iii) information on the extent to
21 which such price discounts, price conces-
22 sions, and rebates apply equally to full-
23 benefit dual eligible Medicare drug plan
24 enrollees and PDP enrollees who are not

1 full-benefit dual eligible Medicare drug
2 plan enrollees; and
3 "(iv) any additional information that
4 the Secretary determines is necessary to
5 enable the Secretary to calculate the aver-
6 age Medicare drug program full-benefit
7 dual eligible rebate amount (as defined in
8 paragraph (3)(C) of such section), and to
9 determine the amount of the rebate re-
10 quired under this section, for such form,
11 strength, and period.
12 Such report shall be in a form consistent with
13 a standard reporting format established by the
14 Secretary.
15 "(C) SUBMISSION TO SECRETARY.—Each
16 PDP sponsor shall promptly transmit a copy of
17 the information reported under subparagraph
18 (B) to the Secretary for the purpose of audit
19 oversight and evaluation.
20 "(D) CONFIDENTIALITY OF INFORMA-
21 TION.—The provisions of subparagraph (D) of
22 section 1927(b)(3), relating to confidentiality of
23 information, shall apply to information reported
24 by PDP sponsors under this paragraph in the
25 same manner that such provisions apply to in-

1 formation disclosed by manufacturers or whole-
2 salers under such section, except—
3 "(i) that any reference to 'this sec-
4 tion' in clause (i) of such subparagraph
5 shall be treated as being a reference to this
6 section;
7 "(ii) the reference to the Director of
8 the Congressional Budget Office in clause
9 (iii) of such subparagraph shall be treated
10 as including a reference to the Medicare
11 Payment Advisory Commission; and
12 "(iii) clause (iv) of such subparagraph
13 shall not apply.
14 "(E) OVERSIGHT.—Information reported
15 under this paragraph may be used by the In-
16 spector General of the Department of Health
17 and Human Services for the statutorily author-
18 ized purposes of audit, investigation, and eval-
19 uations.
20 "(F) PENALTIES FOR FAILURE TO PRO-
21 VIDE TIMELY INFORMATION AND PROVISION OF
22 FALSE INFORMATION.—In the case of a PDP
23 sponsor—
24 "(i) that fails to provide information
25 required under subparagraph (B) on a

1 timely basis, the sponsor is subject to a
2 civil money penalty in the amount of
3 $10,000 for each day in which such infor-
4 mation has not been provided; or
5 "(ii) that knowingly (as defined in
6 section 1128A(i)) provides false informa-
7 tion under such subparagraph, the sponsor
8 is subject to a civil money penalty in an
9 amount not to exceed $100,000 for each
10 item of false information.
11 Such civil money penalties are in addition to
12 other penalties as may be prescribed by law.
13 The provisions of section 1128A (other than
14 subsections (a) and (b)) shall apply to a civil
15 money penalty under this subparagraph in the
16 same manner as such provisions apply to a pen-
17 alty or proceeding under section 1128A(a).".
18 (B) APPLICATION TO MA ORGANIZA-
19 TIONS.—Section 1857(f)(3) of the Social Secu-
20 rity Act (42 U.S.C. 1395w–27(f)(3)) is amend-
21 ed by adding at the end the following:
22 "(D) REPORTING REQUIREMENT RELATED
23 TO REBATE FOR FULL-BENEFIT DUAL ELIGIBLE
24 MEDICARE DRUG PLAN ENROLLEES.—Section
25 1860D–12(b)(7).".

1 (3) DEPOSIT OF REBATES INTO MEDICARE PRE-
2 SCRIPTION DRUG ACCOUNT.—Section 1860D–16(c)
3 of such Act (42 U.S.C. 1395w–116(c)) is amended
4 by adding at the end the following new paragraph:
5 ''(6) REBATE FOR FULL-BENEFIT DUAL ELIGI-
6 BLE MEDICARE DRUG PLAN ENROLLEES.—Amounts
7 paid under a rebate agreement under section
8 1860D–2(f) shall be deposited into the Account and
9 shall be used to pay for all or part of the gradual
10 elimination of the coverage gap under section
11 1860D–2(b)(7).''.

12 **SEC. 1182. DISCOUNTS FOR CERTAIN PART D DRUGS IN**
13 **ORIGINAL COVERAGE GAP.**

14 Section 1860D–2 of the Social Security Act (42
15 U.S.C. 1395w–102), as amended by section 1181(a), is
16 amended—
17 (1) in subsection (b)(4)(C)(ii), by inserting
18 ''subject to subsection (g)(2)(C),'' after ''(ii)'';
19 (2) in subsection (e)(1), in the matter before
20 subparagraph (A), by striking ''subsection (f)'' and
21 inserting ''subsections (f) and (g)'' after ''this sub-
22 section''; and
23 (3) by adding at the end the following new sub-
24 section:

1 "(g) REQUIREMENT FOR MANUFACTURER DISCOUNT
2 AGREEMENT FOR CERTAIN QUALIFYING DRUGS.—
3 "(1) IN GENERAL.—In this part, the term 'cov-
4 ered part D drug' does not include any drug or bio-
5 logic that is manufactured by a manufacturer that
6 has not entered into and have in effect for all quali-
7 fying drugs (as defined in paragraph (5)(A)) a dis-
8 count agreement described in paragraph (2).
9 "(2) DISCOUNT AGREEMENT.—
10 "(A) PERIODIC DISCOUNTS.—A discount
11 agreement under this paragraph shall require
12 the manufacturer involved to provide, to each
13 PDP sponsor with respect to a prescription
14 drug plan or each MA organization with respect
15 to each MA–PD plan, a discount in an amount
16 specified in paragraph (3) for qualifying drugs
17 (as defined in paragraph (5)(A)) of the manu-
18 facturer dispensed to a qualifying enrollee after
19 December 31, 2010, insofar as the individual is
20 in the original gap in coverage (as defined in
21 paragraph (5)(E)).
22 "(B) DISCOUNT AGREEMENT.—Insofar as
23 not inconsistent with this subsection, the Sec-
24 retary shall establish terms and conditions of
25 such agreement, including terms and conditions

1 relating to compliance, similar to the terms and
2 conditions for rebate agreements under para-
3 graphs (2), (3), and (4) of section 1927(b), ex-
4 cept that—
5 ‘‘(i) discounts shall be applied under
6 this subsection to prescription drug plans
7 and MA–PD plans instead of State plans
8 under title XIX;
9 ‘‘(ii) PDP sponsors and MA organiza-
10 tions shall be responsible, instead of
11 States, for provision of necessary utiliza-
12 tion information to drug manufacturers;
13 and
14 ‘‘(iii) sponsors and MA organizations
15 shall be responsible for reporting informa-
16 tion on drug-component negotiated price,
17 instead of other manufacturer prices.
18 ‘‘(C) COUNTING DISCOUNT TOWARD TRUE
19 OUT-OF-POCKET COSTS.—Under the discount
20 agreement, in applying subsection (b)(4), with
21 regard to subparagraph (C)(i) of such sub-
22 section, if a qualified enrollee purchases the
23 qualified drug insofar as the enrollee is in an
24 actual gap of coverage (as defined in paragraph
25 (5)(D)), the amount of the discount under the

1 agreement shall be treated and counted as costs
2 incurred by the plan enrollee.
3 “(3) DISCOUNT AMOUNT.—The amount of the
4 discount specified in this paragraph for a discount
5 period for a plan is equal to 50 percent of the
6 amount of the drug-component negotiated price (as
7 defined in paragraph (5)(C)) for qualifying drugs for
8 the period involved.
9 “(4) ADDITIONAL TERMS.—In the case of a dis-
10 count provided under this subsection with respect to
11 a prescription drug plan offered by a PDP sponsor
12 or an MA–PD plan offered by an MA organization,
13 if a qualified enrollee purchases the qualified drug—
14 “(A) insofar as the enrollee is in an actual
15 gap of coverage (as defined in paragraph
16 (5)(D)), the sponsor or plan shall provide the
17 discount to the enrollee at the time the enrollee
18 pays for the drug; and
19 “(B) insofar as the enrollee is in the por-
20 tion of the original gap in coverage (as defined
21 in paragraph (5)(E)) that is not in the actual
22 gap in coverage, the discount shall not be ap-
23 plied against the negotiated price (as defined in
24 subsection (d)(1)(B)) for the purpose of calcu-
25 lating the beneficiary payment.

1 "(5) DEFINITIONS.—In this subsection:
2 "(A) QUALIFYING DRUG.—The term
3 'qualifying drug' means, with respect to a pre-
4 scription drug plan or MA–PD plan, a drug or
5 biological product that—
6 "(i)(I) is a drug produced or distrib-
7 uted under an original new drug applica-
8 tion approved by the Food and Drug Ad-
9 ministration, including a drug product
10 marketed by any cross-licensed producers
11 or distributors operating under the new
12 drug application;
13 "(II) is a drug that was originally
14 marketed under an original new drug ap-
15 plication approved by the Food and Drug
16 Administration; or
17 "(III) is a biological product as ap-
18 proved under Section 351(a) of the Public
19 Health Services Act;
20 "(ii) is covered under the formulary of
21 the plan; and
22 "(iii) is dispensed to an individual
23 who is in the original gap in coverage.
24 "(B) QUALIFYING ENROLLEE.—The term
25 'qualifying enrollee' means an individual en-

1 rolled in a prescription drug plan or MA–PD
2 plan other than such an individual who is a
3 subsidy-eligible individual (as defined in section
4 1860D–14(a)(3)).
5 "(C) DRUG-COMPONENT NEGOTIATED
6 PRICE.—The term 'drug-component negotiated
7 price' means, with respect to a qualifying drug,
8 the negotiated price (as defined in subsection
9 (d)(1)(B)), as determined without regard to any
10 dispensing fee, of the drug under the prescrip-
11 tion drug plan or MA–PD plan involved.
12 "(D) ACTUAL GAP IN COVERAGE.—The
13 term 'actual gap in coverage' means the gap in
14 prescription drug coverage that occurs between
15 the initial coverage limit (as modified under
16 subparagraph (B) of subsection (b)(7)) and the
17 annual out-of-pocket threshold (as modified
18 under subparagraph (C) of such subsection).
19 "(E) ORIGINAL GAP IN COVERAGE.—The
20 term 'original in gap coverage' means the gap
21 in prescription drug coverage that would occur
22 between the initial coverage limit (described in
23 subsection (b)(3)) and the out-of-pocket thresh-
24 old (as defined in subsection (b)(4))(B) if sub-
25 section (b)(7) did not apply.".

1 **SEC. 1183. REPEAL OF PROVISION RELATING TO SUBMIS-**
2 **SION OF CLAIMS BY PHARMACIES LOCATED**
3 **IN OR CONTRACTING WITH LONG-TERM CARE**
4 **FACILITIES.**

5 (a) PART D SUBMISSION.—Section 1860D–12(b) of
6 the Social Security Act (42 U.S.C. 1395w–112(b)), as
7 amended by section 172(a)(1) of Public Law 110–275, is
8 amended by striking paragraph (5) and redesignating
9 paragraph (6) and paragraph (7), as added by section
10 1181(b)(2), as paragraph (5) and paragraph (6), respec-
11 tively.

12 (b) SUBMISSION TO MA–PD PLANS.—Section
13 1857(f)(3) of the Social Security Act (42 U.S.C. 1395w-
14 27(f)(3)), as added by section 171(b) of Public Law 110–
15 275 and amended by section 172(a)(2) of such Public
16 Law, is amended by striking subparagraph (B) and redes-
17 ignating subparagraph (C) as subparagraph (B).

18 (c) EFFECTIVE DATE.—The amendments made by
19 this section shall apply for contract years beginning with
20 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;

1 "(II) under a State Pharma-
2 ceutical Assistance Program;
3 "(III) by the Indian Health Serv-
4 ice, an Indian tribe or tribal organiza-
5 tion, or an urban Indian organization
6 (as defined in section 4 of the Indian
7 Health Care Improvement Act); or
8 "(IV) under an AIDS Drug As-
9 sistance Program under part B of
10 title XXVI of the Public Health Serv-
11 ice Act.".
12 (b) EFFECTIVE DATE.—The amendments made by
13 subsection (a) shall apply to costs incurred on or after
14 January 1, 2011.

15 **SEC. 1185. PERMITTING MID-YEAR CHANGES IN ENROLL-**
16 **MENT FOR FORMULARY CHANGES THAT AD-**
17 **VERSELY IMPACT AN ENROLLEE.**

18 (a) IN GENERAL.—Section 1860D–1(b)(3) of the So-
19 cial Security Act (42 U.S.C. 1395w–101(b)(3)) is amend-
20 ed by adding at the end the following new subparagraph:
21 "(F) CHANGE IN FORMULARY RESULTING
22 IN INCREASE IN COST-SHARING.—
23 "(i) IN GENERAL.—Except as pro-
24 vided in clause (ii), in the case of an indi-
25 vidual enrolled in a prescription drug plan

1 (or MA–PD plan) who has been prescribed
2 and is using a covered part D drug while
3 so enrolled, if the formulary of the plan is
4 materially changed (other than at the end
5 of a contract year) so to reduce the cov-
6 erage (or increase the cost-sharing) of the
7 drug under the plan.
8 ''(ii) EXCEPTION.—Clause (i) shall
9 not apply in the case that a drug is re-
10 moved from the formulary of a plan be-
11 cause of a recall or withdrawal of the drug
12 issued by the Food and Drug Administra-
13 tion, because the drug is replaced with a
14 generic drug that is a therapeutic equiva-
15 lent, or because of utilization management
16 applied to—
17 ''(I) a drug whose labeling in-
18 cludes a boxed warning required by
19 the Food and Drug Administration
20 under section 210.57(c)(1) of title 21,
21 Code of Federal Regulations (or a
22 successor regulation); or
23 ''(II) a drug required under sub-
24 section (c)(2) of section 505–1 of the
25 Federal Food, Drug, and Cosmetic

1 Act to have a Risk Evaluation and
2 Management Strategy that includes
3 elements under subsection (f) of such
4 section.''.

5 (b) EFFECTIVE DATE.—The amendment made by
6 subsection (a) shall apply to contract years beginning on
7 or after January 1, 2011.

8 Subtitle F—Medicare Rural Access 9 Protections

10 SEC. 1191. TELEHEALTH EXPANSION AND ENHANCEMENTS.

11 .

12 (a) ADDITIONAL TELEHEALTH SITE.—
13 (1) IN GENERAL.—Paragraph (4)(C)(ii) of sec-
14 tion 1834(m) of the Social Security Act (42 U.S.C.
15 1395m(m)) is amended by adding at the end the fol-
16 lowing new subclause:
17 ''(IX) A renal dialysis facility.''
18 (2) EFFECTIVE DATE.—The amendment made
19 by paragraph (1) shall apply to services furnished on
20 or after January 1, 2011.
21 (b) TELEHEALTH ADVISORY COMMITTEE.—
22 (1) ESTABLISHMENT.—Section 1868 of the So-
23 cial Security Act (42 U.S.C. 1395ee) is amended—

1 (A) in the heading, by adding at the end
2 the following: "TELEHEALTH ADVISORY COM-
3 MITTEE"; and
4 (B) by adding at the end the following new
5 subsection:
6 "(c) TELEHEALTH ADVISORY COMMITTEE.—
7 "(1) IN GENERAL.—The Secretary shall appoint
8 a Telehealth Advisory Committee (in this subsection
9 referred to as the 'Advisory Committee') to make
10 recommendations to the Secretary on policies of the
11 Centers for Medicare & Medicaid Services regarding
12 telehealth services as established under section
13 1834(m), including the appropriate addition or dele-
14 tion of services (and HCPCS codes) to those speci-
15 fied in paragraphs (4)(F)(i) and (4)(F)(ii) of such
16 section and for authorized payment under paragraph
17 (1) of such section.
18 "(2) MEMBERSHIP; TERMS.—
19 "(A) MEMBERSHIP.—
20 "(i) IN GENERAL.—The Advisory
21 Committee shall be composed of 9 mem-
22 bers, to be appointed by the Secretary, of
23 whom—
24 "(I) 5 shall be practicing physi-
25 cians;

1 "(II) 2 shall be practicing non-
2 physician health care practitioners;
3 and
4 "(III) 2 shall be administrators
5 of telehealth programs.
6 "(ii) REQUIREMENTS FOR APPOINT-
7 ING MEMBERS.—In appointing members of
8 the Advisory Committee, the Secretary
9 shall—
10 "(I) ensure that each member
11 has prior experience with the practice
12 of telemedicine or telehealth;
13 "(II) give preference to individ-
14 uals who are currently providing tele-
15 medicine or telehealth services or who
16 are involved in telemedicine or tele-
17 health programs;
18 "(III) ensure that the member-
19 ship of the Advisory Committee rep-
20 resents a balance of specialties and
21 geographic regions; and
22 "(IV) take into account the rec-
23 ommendations of stakeholders.

1 "(B) TERMS.—The members of the Advi-
2 sory Committee shall serve for such term as the
3 Secretary may specify.
4 "(C) CONFLICTS OF INTEREST.—An advi-
5 sory committee member may not participate
6 with respect to a particular matter considered
7 in an advisory committee meeting if such mem-
8 ber (or an immediate family member of such
9 member) has a financial interest that could be
10 affected by the advice given to the Secretary
11 with respect to such matter.
12 "(3) MEETINGS.—The Advisory Committee
13 shall meet twice each calendar year and at such
14 other times as the Secretary may provide.
15 "(4) PERMANENT COMMITTEE.—Section 14 of
16 the Federal Advisory Committee Act (5 U.S.C.
17 App.) shall not apply to the Advisory Committee."
18 (2) FOLLOWING RECOMMENDATIONS.—Section
19 1834(m)(4)(F) of such Act (42 U.S.C.
20 1395m(m)(4)(F)) is amended by adding at the end
21 the following new clause:
22 "(iii) RECOMMENDATIONS OF THE
23 TELEHEALTH ADVISORY COMMITTEE.—In
24 making determinations under clauses (i)
25 and (ii), the Secretary shall take into ac-

1 count the recommendations of the Tele-
2 health Advisory Committee (established
3 under section 1868(c)) when adding or de-
4 leting services (and HCPCS codes) and in
5 establishing policies of the Centers for
6 Medicare & Medicaid Services regarding
7 the delivery of telehealth services. If the
8 Secretary does not implement such a rec-
9 ommendation, the Secretary shall publish
10 in the Federal Register a statement re-
11 garding the reason such recommendation
12 was not implemented.''

13 (3) WAIVER OF ADMINISTRATIVE LIMITA-
14 TION.—The Secretary of Health and Human Serv-
15 ices shall establish the Telehealth Advisory Com-
16 mittee under the amendment made by paragraph (1)
17 notwithstanding any limitation that may apply to
18 the number of advisory committees that may be es-
19 tablished (within the Department of Health and
20 Human Services or otherwise).

21 (c) CREDENTIALING TELEMEDICINE PRACTI-
22 TIONERS.—Section 1834(m) of such Act (42 U.S.C.
23 1395m(m)) is amended by adding at the end the following
24 new paragraph:

1 "(5) HOSPITAL CREDENTIALING OF TELEMEDI-
2 CINE PRACTITIONERS.—A telemedicine practitioner
3 that is credentialed by a hospital in compliance with
4 the Joint Commission Standards for Telemedicine
5 shall be considered in compliance with conditions of
6 participation nd reimbursement credentialing re-
7 quirements under this title for telemedicine serv-
8 ices.".

9 **SEC. 1192. EXTENSION OF OUTPATIENT HOLD HARMLESS**
10 **PROVISION.**

11 Section 1833(t)(7)(D)(i) of the Social Security Act
12 (42 U.S.C. 1395l(t)(7)(D)(i)) is amended—
13 (1) in subclause (II)—
14 (A) in the first sentence, by striking
15 '"2010"and inserting "2012"; and
16 (B) in the second sentence, by striking "or
17 2009" and inserting ", 2009, 2010, or 2011";
18 and
19 (2) in subclause (III), by striking "January 1,
20 2010" and inserting "January 1, 2012".

21 **SEC. 1193. EXTENSION OF SECTION 508 HOSPITAL RECLAS-**
22 **SIFICATIONS.**

23 Subsection (a) of section 106 of division B of the Tax
24 Relief and Health Care Act of 2006 (42 U.S.C. 1395
25 note), as amended by section 117 of the Medicare, Med-

1 icaid, and SCHIP Extension Act of 2007 (Public Law
2 110–173) and section 124 of the Medicare Improvements
3 for Patients and Providers Act of 2008 (Public Law 110–
4 275), is amended by striking ''September 30, 2009'' and
5 inserting ''September 30, 2011''.

6 **SEC. 1194. EXTENSION OF GEOGRAPHIC FLOOR FOR WORK.**

7 Section 1848(e)(1)(E) of the Social Security Act (42
8 U.S.C. 1395w–4(e)(1)(E)) is amended by striking ''before
9 January 1, 2010'' and inserting ''before January 1,
10 2012''.

11 **SEC. 1195. EXTENSION OF PAYMENT FOR TECHNICAL COM-**
12 **PONENT OF CERTAIN PHYSICIAN PATHOL-**
13 **OGY SERVICES.**

14 Section 542(c) of the Medicare, Medicaid, and
15 SCHIP Benefits Improvement and Protection Act of 2000
16 (as enacted into law by section 1(a)(6) of Public Law 106–
17 554), as amended by section 732 of the Medicare Prescrip-
18 tion Drug, Improvement, and Modernization Act of 2003
19 (42 U.S.C. 1395w–4 note), section 104 of division B of
20 the Tax Relief and Health Care Act of 2006 (42 U.S.C.
21 1395w–4 note), section 104 of the Medicare, Medicaid,
22 and SCHIP Extension Act of 2007 (Public Law 110–
23 173), and section 136 of the Medicare Improvements for
24 Patients and Providers Act of 1008 (Public Law 110–

1 275), is amended by striking ''and 2009'' and inserting
2 ''2009, 2010, and 2011''.

3 **SEC. 1196. EXTENSION OF AMBULANCE ADD-ONS.**

4 (a) IN GENERAL.—Section 1834(l)(13) of the Social
5 Security Act (42 U.S.C. 1395m(l)(13)) is amended—
6 (1) in subparagraph (A)—
7 (A) in the matter preceding clause (i), by
8 striking ''before January 1, 2010'' and insert-
9 ing ''before January 1, 2012''; and
10 (B) in each of clauses (i) and (ii), by strik-
11 ing ''before January 1, 2010'' and inserting
12 ''before January 1, 2012''.
13 (b) AIR AMBULANCE IMPROVEMENTS.—Section
14 146(b)(1) of the Medicare Improvements for Patients and
15 Providers Act of 2008 (Public Law 110–275) is amended
16 by striking ''ending on December 31, 2009'' and inserting
17 ''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;

1 (D) by inserting after subclause (II) the
2 following new subclauses:
3 "(III) for 2012, $17,000 (or
4 $34,000 in the case of the combined
5 value of the individual's assets or re-
6 sources and the assets or resources of
7 the individual's spouse); and
8 "(IV) for a subsequent year, the
9 dollar amounts specified in this sub-
10 clause (or subclause (III)) for the pre-
11 vious year increased by the annual
12 percentage increase in the consumer
13 price index (all items; U.S. city aver-
14 age) as of September of such previous
15 year."; and
16 (E) in the last sentence, by inserting "or
17 (IV)" after "subclause (II)".
18 (3) APPLICATION OF LIS TEST UNDER MEDI-
19 CARE SAVINGS PROGRAM.—Section 1905(p)(1)(C) of
20 such Act (42 U.S.C. 1396d(p)(1)(C)) is amended—
21 (A) by striking "effective beginning with
22 January 1, 2010" and inserting "effective for
23 the period beginning with January 1, 2010, and
24 ending with December 31, 2011"; and

1 (B) by inserting before the period at the
2 end the following: "or, effective beginning with
3 January 1, 2012, whose resources (as so deter-
4 mined) do not exceed the maximum resource
5 level applied for the year under subparagraph
6 (E) of section 1860D–14(a)(3) (determined
7 without regard to the life insurance policy ex-
8 clusion provided under subparagraph (G) of
9 such section) applicable to an individual or to
10 the individual and the individual's spouse (as
11 the case may be)".

12 (b) EFFECTIVE DATE.—The amendments made by
13 subsection (a) shall apply to eligibility determinations for
14 income-related subsidies and medicare cost-sharing fur-
15 nished for periods beginning on or after January 1, 2012.

16 **SEC. 1202. ELIMINATION OF PART D COST-SHARING FOR**
17 **CERTAIN NON-INSTITUTIONALIZED FULL-**
18 **BENEFIT DUAL ELIGIBLE INDIVIDUALS.**

19 (a) IN GENERAL.—Section 1860D–14(a)(1)(D)(i) of
20 the Social Security Act (42 U.S.C. 1395w–
21 114(a)(1)(D)(i)) is amended—
22 (1) by striking "INSTITUTIONALIZED INDIVID-
23 UALS.—In" and inserting "ELIMINATION OF COST-
24 SHARING FOR CERTAIN FULL-BENEFIT DUAL ELIGI-
25 BLE INDIVIDUALS.—

1 "(I) INSTITUTIONALIZED INDI-
2 VIDUALS.—In"; and
3 (2) by adding at the end the following new sub-
4 clause:
5 "(II) CERTAIN OTHER INDIVID-
6 UALS.—In the case of an individual
7 who is a full-benefit dual eligible indi-
8 vidual and with respect to whom there
9 has been a determination that but for
10 the provision of home and community
11 based care (whether under section
12 1915, 1932, or under a waiver under
13 section 1115) the individual would re-
14 quire the level of care provided in a
15 hospital or a nursing facility or inter-
16 mediate care facility for the mentally
17 retarded the cost of which could be re-
18 imbursed under the State plan under
19 title XIX, the elimination of any bene-
20 ficiary coinsurance described in sec-
21 tion 1860D–2(b)(2) (for all amounts
22 through the total amount of expendi-
23 tures at which benefits are available
24 under section 1860D–2(b)(4)).".

1 (b) EFFECTIVE DATE.—The amendments made by
2 subsection (a) shall apply to drugs dispensed on or after
3 January 1, 2011.

4 **SEC. 1203. ELIMINATING BARRIERS TO ENROLLMENT.**

5 (a) ADMINISTRATIVE VERIFICATION OF INCOME AND
6 RESOURCES UNDER THE LOW-INCOME SUBSIDY PRO-
7 GRAM.—
8 (1) IN GENERAL.—Clause (iii) of section
9 1860D–14(a)(3)(E) of the Social Security Act (42
10 U.S.C. 1395w–114(a)(3)(E)) is amended to read as
11 follows:
12 "(iii) CERTIFICATION OF INCOME AND
13 RESOURCES.—For purposes of applying
14 this section—
15 "(I) an individual shall be per-
16 mitted to apply on the basis of self-
17 certification of income and resources;
18 and
19 "(II) matters attested to in the
20 application shall be subject to appro-
21 priate methods of verification without
22 the need of the individual to provide
23 additional documentation, except in
24 extraordinary situations as determined
25 by the Commissioner.".

1 (2) EFFECTIVE DATE.—The amendment made
2 by paragraph (1) shall apply beginning January 1,
3 2010.

4 (b) DISCLOSURES TO FACILITATE IDENTIFICATION
5 OF INDIVIDUALS LIKELY TO BE INELIGIBLE FOR THE
6 LOW-INCOME ASSISTANCE UNDER THE MEDICARE PRE-
7 SCRIPTION DRUG PROGRAM TO ASSIST SOCIAL SECURITY
8 ADMINISTRATION'S OUTREACH TO ELIGIBLE INDIVID-
9 UALS.—For provision authorizing disclosure of return in-
10 formation to facilitate identification of individuals likely
11 to be ineligible for low-income subsidies under Medicare
12 prescription drug program, see section 1801.

13 **SEC. 1204. ENHANCED OVERSIGHT RELATING TO REIM-**
14 **BURSEMENTS FOR RETROACTIVE LOW IN-**
15 **COME SUBSIDY ENROLLMENT.**

16 (a) IN GENERAL.—In the case of a retroactive LIS
17 enrollment beneficiary who is enrolled under a prescription
18 drug plan under part D of title XVIII of the Social Secu-
19 rity Act (or an MA–PD plan under part C of such title),
20 the beneficiary (or any eligible third party) is entitled to
21 reimbursement by the plan for covered drug costs incurred
22 by the beneficiary during the retroactive coverage period
23 of the beneficiary in accordance with subsection (b) and
24 in the case of such a beneficiary described in subsection
25 (c)(4)(A)(i), such reimbursement shall be made automati-

1 cally by the plan upon receipt of appropriate notice the
2 beneficiary is eligible for assistance described in such sub-
3 section (c)(4)(A)(i) without further information required
4 to be filed with the plan by the beneficiary.

5 (b) ADMINISTRATIVE REQUIREMENTS RELATING TO
6 REIMBURSEMENTS.—

7 (1) LINE-ITEM DESCRIPTION.—Each reimburse-
8 ment made by a prescription drug plan or MA–PD
9 plan under subsection (a) shall include a line-item
10 description of the items for which the reimbursement
11 is made.

12 (2) TIMING OF REIMBURSEMENTS.—A prescrip-
13 tion drug plan or MA–PD plan must make a reim-
14 bursement under subsection (a) to a retroactive LIS
15 enrollment beneficiary, with respect to a claim, not
16 later than 45 days after—

17 (A) in the case of a beneficiary described
18 in subsection (c)(4)(A)(i), the date on which the
19 plan receives notice from the Secretary that the
20 beneficiary is eligible for assistance described in
21 such subsection; or

22 (B) in the case of a beneficiary described
23 in subsection (c)(4)(A)(ii), the date on which
24 the beneficiary files the claim with the plan.

1 (3) REPORTING REQUIREMENT.—For each
2 month beginning with January 2011, each prescrip-
3 tion drug plan and each MA–PD plan shall report
4 to the Secretary the following:
5 (A) The number of claims the plan has re-
6 adjudicated during the month due to a bene-
7 ficiary becoming retroactively eligible for sub-
8 sidies available under section 1860D–14 of the
9 Social Security Act.
10 (B) The total value of the readjudicated
11 claim amount for the month.
12 (C) The Medicare Health Insurance Claims
13 Number of beneficiaries for whom claims were
14 readjudicated.
15 (D) For the claims described in subpara-
16 graphs (A) and (B), an attestation to the Ad-
17 ministrator of the Centers for Medicare & Med-
18 icaid Services of the total amount of reimburse-
19 ment the plan has provided to beneficiaries for
20 premiums and cost-sharing that the beneficiary
21 overpaid for which the plan received payment
22 from the Centers for Medicare & Medicaid Serv-
23 ices.
24 (c) DEFINITIONS.—For purposes of this section:

1 (1) COVERED DRUG COSTS.—The term ''cov-
2 ered drug costs'' means, with respect to a retroactive
3 LIS enrollment beneficiary enrolled under a pre-
4 scription drug plan under part D of title XVIII of
5 the Social Security Act (or an MA–PD plan under
6 part C of such title), the amount by which—
7 (A) the costs incurred by such beneficiary
8 during the retroactive coverage period of the
9 beneficiary for covered part D drugs, premiums,
10 and cost-sharing under such title; exceeds
11 (B) such costs that would have been in-
12 curred by such beneficiary during such period if
13 the beneficiary had been both enrolled in the
14 plan and recognized by such plan as qualified
15 during such period for the low income subsidy
16 under section 1860D–14 of the Social Security
17 Act to which the individual is entitled.
18 (2) ELIGIBLE THIRD PARTY.—The term ''eligi-
19 ble third party'' means, with respect to a retroactive
20 LIS enrollment beneficiary, an organization or other
21 third party that is owed payment on behalf of such
22 beneficiary for covered drug costs incurred by such
23 beneficiary during the retroactive coverage period of
24 such beneficiary.

1 (3) RETROACTIVE COVERAGE PERIOD.—The
2 term ‘‘retroactive coverage period’’ means—
3 (A) with respect to a retroactive LIS en-
4 rollment beneficiary described in paragraph
5 (4)(A)(i), the period—
6 (i) beginning on the effective date of
7 the assistance described in such paragraph
8 for which the individual is eligible; and
9 (ii) ending on the date the plan effec-
10 tuates the status of such individual as so
11 eligible; and
12 (B) with respect to a retroactive LIS en-
13 rollment beneficiary described in paragraph
14 (4)(A)(ii), the period—
15 (i) beginning on the date the indi-
16 vidual is both entitled to benefits under
17 part A, or enrolled under part B, of title
18 XVIII of the Social Security Act and eligi-
19 ble for medical assistance under a State
20 plan under title XIX of such Act; and
21 (ii) ending on the date the plan effec-
22 tuates the status of such individual as a
23 full-benefit dual eligible individual (as de-
24 fined in section 1935(c)(6) of such Act).

1 (4) RETROACTIVE LIS ENROLLMENT BENE-
2 FICIARY.—
3 (A) IN GENERAL.—The term ''retroactive
4 LIS enrollment beneficiary'' means an indi-
5 vidual who—
6 (i) is enrolled in a prescription drug
7 plan under part D of title XVIII of the So-
8 cial Security Act (or an MA–PD plan
9 under part C of such title) and subse-
10 quently becomes eligible as a full-benefit
11 dual eligible individual (as defined in sec-
12 tion 1935(c)(6) of such Act), an individual
13 receiving a low-income subsidy under sec-
14 tion 1860D–14 of such Act, an individual
15 receiving assistance under the Medicare
16 Savings Program implemented under
17 clauses (i), (iii), and (iv) of section
18 1902(a)(10)(E) of such Act, or an indi-
19 vidual receiving assistance under the sup-
20 plemental security income program under
21 section 1611 of such Act; or
22 (ii) subject to subparagraph (B)(i), is
23 a full-benefit dual eligible individual (as
24 defined in section 1935(c)(6) of such Act)
25 who is automatically enrolled in such a

1 plan under section 1860D–1(b)(1)(C) of
2 such Act.
3 (B) EXCEPTION FOR BENEFICIARIES EN-
4 ROLLED IN RFP PLAN.—
5 (i) IN GENERAL.—In no case shall an
6 individual described in subparagraph
7 (A)(ii) include an individual who is en-
8 rolled, pursuant to a RFP contract de-
9 scribed in clause (ii), in a prescription
10 drug plan offered by the sponsor of such
11 plan awarded such contract.
12 (ii) RFP CONTRACT DESCRIBED.—
13 The RFP contract described in this section
14 is a contract entered into between the Sec-
15 retary and a sponsor of a prescription drug
16 plan pursuant to the Centers for Medicare
17 & Medicaid Services' request for proposals
18 issued on February 17, 2009, relating to
19 Medicare part D retroactive coverage for
20 certain low income beneficiaries, or a simi-
21 lar subsequent request for proposals.

22 **SEC. 1205. INTELLIGENT ASSIGNMENT IN ENROLLMENT.**

23 (a) IN GENERAL.—Section 1860D–1(b)(1)(C) of the
24 Social Security Act (42 U.S.C. 1395w–101(b)(1)(C)) is
25 amended by adding after "PDP region" the following: "or

1 through use of an intelligent assignment process that is
2 designed to maximize the access of such individual to nec-
3 essary prescription drugs while minimizing costs to such
4 individual and to the program under this part to the great-
5 est extent possible. In the case the Secretary enrolls such
6 individuals through use of an intelligent assignment proc-
7 ess, such process shall take into account the extent to
8 which prescription drugs necessary for the individual are
9 covered in the case of a PDP sponsor of a prescription
10 drug plan that uses a formulary, the use of prior author-
11 ization or other restrictions on access to coverage of such
12 prescription drugs by such a sponsor, and the overall qual-
13 ity of a prescription drug plan as measured by quality rat-
14 ings established by the Secretary.''

15 (b) EFFECTIVE DATE.—The amendment made by
16 subsection (a) shall take effect for contract years begin-
17 ning with 2012.

18 **SEC. 1206. SPECIAL ENROLLMENT PERIOD AND AUTOMATIC**
19 **ENROLLMENT PROCESS FOR CERTAIN SUB-**
20 **SIDY ELIGIBLE INDIVIDUALS.**

21 (a) SPECIAL ENROLLMENT PERIOD.—Section
22 1860D–1(b)(3)(D) of the Social Security Act (42 U.S.C.
23 1395w–101(b)(3)(D)) is amended to read as follows:

24 ''(D) SUBSIDY ELIGIBLE INDIVIDUALS.—
25 In the case of an individual (as determined by

1 the Secretary) who is determined under sub-
2 paragraph (B) of section 1860D–14(a)(3) to be
3 a subsidy eligible individual.''.
4 (b) AUTOMATIC ENROLLMENT.—Section 1860D–
5 1(b)(1) of the Social Security Act (42 U.S.C. 1395w–
6 101(b)(1)) is amended by adding at the end the following
7 new subparagraph:
8 ''(D) SPECIAL RULE FOR SUBSIDY ELIGI-
9 BLE INDIVIDUALS.—The process established
10 under subparagraph (A) shall include, in the
11 case of an individual described in section
12 1860D–1(b)(3)(D) who fails to enroll in a pre-
13 scription drug plan or an MA–PD plan during
14 the special enrollment established under such
15 section applicable to such individual, the appli-
16 cation of the assignment process described in
17 subparagraph (C) to such individual in the
18 same manner as such assignment process ap-
19 plies to a part D eligible individual described in
20 such subparagraph (C). Nothing in the previous
21 sentence shall prevent an individual described in
22 such sentence from declining enrollment in a
23 plan determined appropriate by the Secretary
24 (or in the program under this part) or from
25 changing such enrollment.''.

1 (c) EFFECTIVE DATE.—The amendments made by
2 this section shall apply to subsidy determinations made
3 for months beginning with January 2011.

4 **SEC. 1207. APPLICATION OF MA PREMIUMS PRIOR TO RE-**
5 **BATE IN CALCULATION OF LOW INCOME SUB-**
6 **SIDY BENCHMARK.**

7 (a) IN GENERAL.—Section 1860D–14(b)(2)(B)(iii)
8 of the Social Security Act (42 U.S.C. 1395w–
9 114(b)(2)(B)(iii)) is amended by inserting before the pe-
10 riod the following: ''before the application of the monthly
11 rebate computed under section 1854(b)(1)(C)(i) for that
12 plan and year involved''.

13 (b) EFFECTIVE DATE.—The amendment made by
14 subsection (a) shall apply to subsidy determinations made
15 for months beginning with January 2011.

16 Subtitle B—Reducing Health
17 Disparities

18 **SEC. 1221. ENSURING EFFECTIVE COMMUNICATION IN**
19 **MEDICARE.**

20 (a) ENSURING EFFECTIVE COMMUNICATION BY THE
21 CENTERS FOR MEDICARE & MEDICAID SERVICES.—

22 (1) STUDY ON MEDICARE PAYMENTS FOR LAN-
23 GUAGE SERVICES.—The Secretary of Health and
24 Human Services shall conduct a study that examines
25 the extent to which Medicare service providers uti-

1 lize, offer, or make available language services for
2 beneficiaries who are limited English proficient and
3 ways that Medicare should develop payment systems
4 for language services.

5 (2) ANALYSES.—The study shall include an
6 analysis of each of the following:

7 (A) How to develop and structure appro-
8 priate payment systems for language services
9 for all Medicare service providers.

10 (B) The feasibility of adopting a payment
11 methodology for on-site interpreters, including
12 interpreters who work as independent contrac-
13 tors and interpreters who work for agencies
14 that provide on-site interpretation, pursuant to
15 which such interpreters could directly bill Medi-
16 care for services provided in support of physi-
17 cian office services for an LEP Medicare pa-
18 tient.

19 (C) The feasibility of Medicare contracting
20 directly with agencies that provide off-site inter-
21 pretation including telephonic and video inter-
22 pretation pursuant to which such contractors
23 could directly bill Medicare for the services pro-
24 vided in support of physician office services for
25 an LEP Medicare patient.

1 (D) The feasibility of modifying the exist-
2 ing Medicare resource-based relative value scale
3 (RBRVS) by using adjustments (such as multi-
4 pliers or add-ons) when a patient is LEP.
5 (E) How each of options described in a
6 previous paragraph would be funded and how
7 such funding would affect physician payments,
8 a physician's practice, and beneficiary cost-
9 sharing.
10 (F) The extent to which providers under
11 parts A and B of title XVIII of the Social Secu-
12 rity Act, MA organizations offering Medicare
13 Advantage plans under part C of such title and
14 PDP sponsors of a prescription drug plan
15 under part D of such title utilize, offer, or make
16 available language services for beneficiaries with
17 limited English proficiency.
18 (G) The nature and type of language serv-
19 ices provided by States under title XIX of the
20 Social Security Act and the extent to which
21 such services could be utilized by beneficiaries
22 and providers under title XVIII of such Act.
23 (3) VARIATION IN PAYMENT SYSTEM DE-
24 SCRIBED.—The payment systems described in para-
25 graph (2)(A) may allow variations based upon types

1 of service providers, available delivery methods, and
2 costs for providing language services including such
3 factors as—
4 (A) the type of language services provided
5 (such as provision of health care or health care
6 related services directly in a non-English lan-
7 guage by a bilingual provider or use of an inter-
8 preter);
9 (B) type of interpretation services provided
10 (such as in-person, telephonic, video interpreta-
11 tion);
12 (C) the methods and costs of providing
13 language services (including the costs of pro-
14 viding language services with internal staff or
15 through contract with external independent con-
16 tractors or agencies, or both);
17 (D) providing services for languages not
18 frequently encountered in the United States;
19 and
20 (E) providing services in rural areas.
21 (4) REPORT.—The Secretary shall submit a re-
22 port on the study conducted under subsection (a) to
23 appropriate committees of Congress not later than
24 12 months after the date of the enactment of this
25 Act.

1 (5) EXEMPTION FROM PAPERWORK REDUCTION
2 ACT.—Chapter 35 of title 44, United States Code
3 (commonly known as the "Paperwork Reduction
4 Act"), shall not apply for purposes of carrying out
5 this subsection.
6 (6) AUTHORIZATION OF APPROPRIATIONS.—
7 There is authorized to be appropriated to carry out
8 this subsection such sums as are necessary.
9 (b) HEALTH PLANS.—Section 1857(g)(1) of the So-
10 cial Security Act (42 U.S.C. 1395w–27(g)(1)) is amend-
11 ed—
12 (1) by striking "or" at the end of subparagraph
13 (F);
14 (2) by adding "or" at the end of subparagraph
15 (G); and
16 (3) by inserting after subparagraph (G) the fol-
17 lowing new subparagraph:
18 "(H) fails substantially to provide lan-
19 guage services to limited English proficient
20 beneficiaries enrolled in the plan that are re-
21 quired under law;".

1 **SEC. 1222. DEMONSTRATION TO PROMOTE ACCESS FOR**
2 **MEDICARE BENEFICIARIES WITH LIMITED**
3 **ENGLISH PROFICIENCY BY PROVIDING REIM-**
4 **BURSEMENT FOR CULTURALLY AND LINGUIS-**
5 **TICALLY APPROPRIATE SERVICES.**

6 (a) IN GENERAL.—Not later than 6 months after the
7 date of the completion of the study described in section
8 1221(a), the Secretary, acting through the Centers for
9 Medicare & Medicaid Services, shall carry out a dem-
10 onstration program under which the Secretary shall award
11 not fewer than 24 3-year grants to eligible Medicare serv-
12 ice providers (as described in subsection (b)(1)) to improve
13 effective communication between such providers and Medi-
14 care beneficiaries who are living in communities where ra-
15 cial and ethnic minorities, including populations that face
16 language barriers, are underserved with respect to such
17 services. In designing and carrying out the demonstration
18 the Secretary shall take into consideration the results of
19 the study conducted under section 1221(a) and adjust, as
20 appropriate, the distribution of grants so as to better tar-
21 get Medicare beneficiaries who are in the greatest need
22 of language services. The Secretary shall not authorize a
23 grant larger than $500,000 over three years for any grant-
24 ee.

25 (b) ELIGIBILITY; PRIORITY.—

1 (1) ELIGIBILITY.—To be eligible to receive a
2 grant under subsection (a) an entity shall—
3 (A) be—
4 (i) a provider of services under part A
5 of title XVIII of the Social Security Act;
6 (ii) a service provider under part B of
7 such title;
8 (iii) a part C organization offering a
9 Medicare part C plan under part C of such
10 title; or
11 (iv) a PDP sponsor of a prescription
12 drug plan under part D of such title; and
13 (B) prepare and submit to the Secretary
14 an application, at such time, in such manner,
15 and accompanied by such additional informa-
16 tion as the Secretary may require.
17 (2) PRIORITY.—
18 (A) DISTRIBUTION.—To the extent fea-
19 sible, in awarding grants under this section, the
20 Secretary shall award—
21 (i) at least 6 grants to providers of
22 services described in paragraph (1)(A)(i);
23 (ii) at least 6 grants to service pro-
24 viders described in paragraph (1)(A)(ii);

1 (iii) at least 6 grants to organizations
2 described in paragraph (1)(A)(iii); and
3 (iv) at least 6 grants to sponsors de-
4 scribed in paragraph (1)(A)(iv).
5 (B) FOR COMMUNITY ORGANIZATIONS.—
6 The Secretary shall give priority to applicants
7 that have developed partnerships with commu-
8 nity organizations or with agencies with experi-
9 ence in language access.
10 (C) VARIATION IN GRANTEES.—The Sec-
11 retary shall also ensure that the grantees under
12 this section represent, among other factors,
13 variations in—
14 (i) different types of language services
15 provided and of service providers and orga-
16 nizations under parts A through D of title
17 XVIII of the Social Security Act;
18 (ii) languages needed and their fre-
19 quency of use;
20 (iii) urban and rural settings;
21 (iv) at least two geographic regions,
22 as defined by the Secretary; and
23 (v) at least two large metropolitan
24 statistical areas with diverse populations.
25 (c) USE OF FUNDS.—

1 (1) In general.—A grantee shall use grant
2 funds received under this section to pay for the pro-
3 vision of competent language services to Medicare
4 beneficiaries who are limited English proficient.
5 Competent interpreter services may be provided
6 through on-site interpretation, telephonic interpreta-
7 tion, or video interpretation or direct provision of
8 health care or health care related services by a bilin-
9 gual health care provider. A grantee may use bilin-
10 gual providers, staff, or contract interpreters. A
11 grantee may use grant funds to pay for competent
12 translation services. A grantee may use up to 10
13 percent of the grant funds to pay for administrative
14 costs associated with the provision of competent lan-
15 guage services and for reporting required under sub-
16 section (e).

17 (2) Organizations.—Grantees that are part C
18 organizations or PDP sponsors must ensure that
19 their network providers receive at least 50 percent of
20 the grant funds to pay for the provision of com-
21 petent language services to Medicare beneficiaries
22 who are limited English proficient, including physi-
23 cians and pharmacies.

24 (3) Determination of payments for lan-
25 guage services.—Payments to grantees shall be

1 calculated based on the estimated numbers of lim-
2 ited English proficient Medicare beneficiaries in a
3 grantee's service area utilizing—
4 (A) data on the numbers of limited
5 English proficient individuals who speak
6 English less than "very well" from the most re-
7 cently available data from the Bureau of the
8 Census or other State-based study the Sec-
9 retary determines likely to yield accurate data
10 regarding the number of such individuals served
11 by the grantee; or
12 (B) the grantee's own data if the grantee
13 routinely collects data on Medicare bene-
14 ficiaries' primary language in a manner deter-
15 mined by the Secretary to yield accurate data
16 and such data shows greater numbers of limited
17 English proficient individuals than the data list-
18 ed in subparagraph (A).
19 (4) LIMITATIONS.—
20 (A) REPORTING.—Payments shall only be
21 provided under this section to grantees that re-
22 port their costs of providing language services
23 as required under subsection (e) and may be
24 modified annually at the discretion of the Sec-
25 retary. If a grantee fails to provide the reports

1 under such section for the first year of a grant,
2 the Secretary may terminate the grant and so-
3 licit applications from new grantees to partici-
4 pate in the subsequent two years of the dem-
5 onstration program.

6 (B) TYPE OF SERVICES.—

7 (i) IN GENERAL.—Subject to clause
8 (ii), payments shall be provided under this
9 section only to grantees that utilize com-
10 petent bilingual staff or competent inter-
11 preter or translation services which—

12 (I) if the grantee operates in a
13 State that has statewide health care
14 interpreter standards, meet the State
15 standards currently in effect; or

16 (II) if the grantee operates in a
17 State that does not have statewide
18 health care interpreter standards, uti-
19 lizes competent interpreters who fol-
20 low the National Council on Inter-
21 preting in Health Care's Code of Eth-
22 ics and Standards of Practice.

23 (ii) EXEMPTIONS.—The requirements
24 of clause (i) shall not apply—

1 (I) in the case of a Medicare ben-
2 eficiary who is limited English pro-
3 ficient (who has been informed in the
4 beneficiary's primary language of the
5 availability of free interpreter and
6 translation services) and who requests
7 the use of family, friends, or other
8 persons untrained in interpretation or
9 translation and the grantee documents
10 the request in the beneficiary's record;
11 and
12 (II) in the case of a medical
13 emergency where the delay directly as-
14 sociated with obtaining a competent
15 interpreter or translation services
16 would jeopardize the health of the pa-
17 tient.
18 Nothing in clause (ii)(II) shall be con-
19 strued to exempt emergency rooms or simi-
20 lar entities that regularly provide health
21 care services in medical emergencies from
22 having in place systems to provide com-
23 petent interpreter and translation services
24 without undue delay.

1 (d) ASSURANCES.—Grantees under this section
2 shall—
3 (1) ensure that appropriate clinical and support
4 staff receive ongoing education and training in lin-
5 guistically appropriate service delivery;
6 (2) ensure the linguistic competence of bilingual
7 providers;
8 (3) offer and provide appropriate language serv-
9 ices at no additional charge to each patient with lim-
10 ited English proficiency at all points of contact, in
11 a timely manner during all hours of operation;
12 (4) notify Medicare beneficiaries of their right
13 to receive language services in their primary lan-
14 guage;
15 (5) post signage in the languages of the com-
16 monly encountered group or groups present in the
17 service area of the organization; and
18 (6) ensure that—
19 (A) primary language data are collected
20 for recipients of language services; and
21 (B) consistent with the privacy protections
22 provided under the regulations promulgated
23 pursuant to section 264(c) of the Health Insur-
24 ance Portability and Accountability Act of 1996
25 (42 U.S.C. 1320d–2 note), if the recipient of

1 language services is a minor or is incapacitated,
2 the primary language of the parent or legal
3 guardian is collected and utilized.
4 (e) REPORTING REQUIREMENTS.—Grantees under
5 this section shall provide the Secretary with reports at the
6 conclusion of the each year of a grant under this section.
7 Each report shall include at least the following informa-
8 tion:
9 (1) The number of Medicare beneficiaries to
10 whom language services are provided.
11 (2) The languages of those Medicare bene-
12 ficiaries.
13 (3) The types of language services provided
14 (such as provision of services directly in non-English
15 language by a bilingual health care provider or use
16 of an interpreter).
17 (4) Type of interpretation (such as in-person,
18 telephonic, or video interpretation).
19 (5) The methods of providing language services
20 (such as staff or contract with external independent
21 contractors or agencies).
22 (6) The length of time for each interpretation
23 encounter.

1 (7) The costs of providing language services
2 (which may be actual or estimated, as determined by
3 the Secretary).
4 (f) NO COST SHARING.—Limited English proficient
5 Medicare beneficiaries shall not have to pay cost-sharing
6 or co-pays for language services provided through this
7 demonstration program.
8 (g) EVALUATION AND REPORT.—The Secretary shall
9 conduct an evaluation of the demonstration program
10 under this section and shall submit to the appropriate
11 committees of Congress a report not later than 1 year
12 after the completion of the program. The report shall in-
13 clude the following:
14 (1) An analysis of the patient outcomes and
15 costs of furnishing care to the limited English pro-
16 ficient Medicare beneficiaries participating in the
17 project as compared to such outcomes and costs for
18 limited English proficient Medicare beneficiaries not
19 participating.
20 (2) The effect of delivering culturally and lin-
21 guistically appropriate services on beneficiary access
22 to care, utilization of services, efficiency and cost-ef-
23 fectiveness of health care delivery, patient satisfac-
24 tion, and select health outcomes.

1 (3) Recommendations, if any, regarding the ex-
2 tension of such project to the entire Medicare pro-
3 gram.
4 (h) GENERAL PROVISIONS.—Nothing in this section
5 shall be construed to limit otherwise existing obligations
6 of recipients of Federal financial assistance under title VI
7 of the Civil Rights Act of 1964 (42 U.S.C. 2000(d) et
8 seq.) or any other statute.
9 (i) AUTHORIZATION OF APPROPRIATIONS.—There
10 are authorized to be appropriated to carry out this section
11 $16,000,000 for each fiscal year of the demonstration pro-
12 gram.
13 **SEC. 1223. IOM REPORT ON IMPACT OF LANGUAGE ACCESS**
14 **SERVICES.**
15 (a) IN GENERAL.—The Secretary of Health and
16 Human Services shall enter into an arrangement with the
17 Institute of Medicine under which the Institute will pre-
18 pare and publish, not later than 3 years after the date
19 of the enactment of this Act, a report on the impact of
20 language access services on the health and health care of
21 limited English proficient populations.
22 (b) CONTENTS.—Such report shall include—
23 (1) recommendations on the development and
24 implementation of policies and practices by health

1 care organizations and providers for limited English
2 proficient patient populations;
3 (2) a description of the effect of providing lan-
4 guage access services on quality of health care and
5 access to care and reduced medical error; and
6 (3) a description of the costs associated with or
7 savings related to provision of language access serv-
8 ices.

9 **SEC. 1224. DEFINITIONS.**

10 In this subtitle:
11 (1) BILINGUAL.—The term ''bilingual'' with re-
12 spect to an individual means a person who has suffi-
13 cient degree of proficiency in two languages and can
14 ensure effective communication can occur in both
15 languages.
16 (2) COMPETENT INTERPRETER SERVICES.—The
17 term ''competent interpreter services'' means a
18 trans-language rendition of a spoken message in
19 which the interpreter comprehends the source lan-
20 guage and can speak comprehensively in the target
21 language to convey the meaning intended in the
22 source language. The interpreter knows health and
23 health-related terminology and provides accurate in-
24 terpretations by choosing equivalent expressions that
25 convey the best matching and meaning to the source

1 language and captures, to the greatest possible ex-
2 tent, all nuances intended in the source message.
3 (3) COMPETENT TRANSLATION SERVICES.—The
4 term "competent translation services" means a
5 trans-language rendition of a written document in
6 which the translator comprehends the source lan-
7 guage and can write comprehensively in the target
8 language to convey the meaning intended in the
9 source language. The translator knows health and
10 health-related terminology and provides accurate
11 translations by choosing equivalent expressions that
12 convey the best matching and meaning to the source
13 language and captures, to the greatest possible ex-
14 tent, all nuances intended in the source document.
15 (4) EFFECTIVE COMMUNICATION.—The term
16 "effective communication" means an exchange of in-
17 formation between the provider of health care or
18 health care-related services and the limited English
19 proficient recipient of such services that enables lim-
20 ited English proficient individuals to access, under-
21 stand, and benefit from health care or health care-
22 related services.
23 (5) INTERPRETING/INTERPRETATION.—The
24 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 indi-

1 vidual to effectively communicate with clinical or
2 nonclinical staff at an entity providing health care or
3 health care related services.

4 (11) MEDICARE BENEFICIARY.—The term
5 ''Medicare beneficiary'' means an individual entitled
6 to benefits under part A of title XVIII of the Social
7 Security Act or enrolled under part B of such title.

8 (12) MEDICARE PROGRAM.—The term ''Medi-
9 care program'' means the programs under parts A
10 through D of title XVIII of the Social Security Act.

11 (13) SERVICE PROVIDER.—The term ''service
12 provider'' includes all suppliers, providers of services,
13 or entities under contract to provide coverage, items
14 or services under any part of title XVIII of the So-
15 cial Security Act.

16 Subtitle C—Miscellaneous 17 Improvements

18 SEC. 1231. EXTENSION OF THERAPY CAPS EXCEPTIONS 19 PROCESS.

20 Section 1833(g)(5) of the Social Security Act (42
21 U.S.C. 1395l(g)(5)), as amended by section 141 of the
22 Medicare Improvements for Patients and Providers Act of
23 2008 (Public Law 110–275), is amended by striking ''De-
24 cember 31, 2009'' and inserting ''December 31, 2011''.

1 **SEC. 1232. EXTENDED MONTHS OF COVERAGE OF IMMUNO-**
2 **SUPPRESSIVE DRUGS FOR KIDNEY TRANS-**
3 **PLANT PATIENTS AND OTHER RENAL DIALY-**
4 **SIS PROVISIONS.**

5 (a) PROVISION OF APPROPRIATE COVERAGE OF IM-
6 MUNOSUPPRESSIVE DRUGS UNDER THE MEDICARE PRO-
7 GRAM FOR KIDNEY TRANSPLANT RECIPIENTS.—
8 (1) CONTINUED ENTITLEMENT TO IMMUNO-
9 SUPPRESSIVE DRUGS.—
10 (A) KIDNEY TRANSPLANT RECIPIENTS.—
11 Section 226A(b)(2) of the Social Security Act
12 (42 U.S.C. 426–1(b)(2)) is amended by insert-
13 ing ''(except for coverage of immunosuppressive
14 drugs under section 1861(s)(2)(J))'' before '',
15 with the thirty-sixth month''.
16 (B) APPLICATION.—Section 1836 of such
17 Act (42 U.S.C. 1395o) is amended—
18 (i) by striking ''Every individual who''
19 and inserting ''(a) IN GENERAL.–Every in-
20 dividual who''; and
21 (ii) by adding at the end the following
22 new subsection:
23 ''(b) SPECIAL RULES APPLICABLE TO INDIVIDUALS
24 ONLY ELIGIBLE FOR COVERAGE OF IMMUNOSUPPRESSIVE
25 DRUGS.—

1 "(1) IN GENERAL.—In the case of an individual
2 whose eligibility for benefits under this title has
3 ended on or after January 1, 2012, except for the
4 coverage of immunosuppressive drugs by reason of
5 section 226A(b)(2), the following rules shall apply:
6 "(A) The individual shall be deemed to be
7 enrolled under this part for purposes of receiv-
8 ing coverage of such drugs.
9 "(B) The individual shall be responsible
10 for providing for payment of the portion of the
11 premium under section 1839 which is not cov-
12 ered under the Medicare savings program (as
13 defined in section 1144(c)(7)) in order to re-
14 ceive such coverage.
15 "(C) The provision of such drugs shall be
16 subject to the application of—
17 "(i) the deductible under section
18 1833(b); and
19 "(ii) the coinsurance amount applica-
20 ble for such drugs (as determined under
21 this part).
22 "(D) If the individual is an inpatient of a
23 hospital or other entity, the individual is enti-
24 tled to receive coverage of such drugs under
25 this part.

1 "(2) ESTABLISHMENT OF PROCEDURES IN
2 ORDER TO IMPLEMENT COVERAGE.—The Secretary
3 shall establish procedures for—
4 "(A) identifying individuals that are enti-
5 tled to coverage of immunosuppressive drugs by
6 reason of section 226A(b)(2); and
7 "(B) distinguishing such individuals from
8 individuals that are enrolled under this part for
9 the complete package of benefits under this
10 part.".
11 (C) TECHNICAL AMENDMENT TO CORRECT
12 DUPLICATE SUBSECTION DESIGNATION.—Sub-
13 section (d) of section 226A of such Act (42
14 U.S.C. 426–1), as added by section
15 201(a)(3)(D)(ii) of the Social Security Inde-
16 pendence and Program Improvements Act of
17 1994 (Public Law 103–296; 108 Stat. 1497), is
18 redesignated as subsection (d).
19 (2) EXTENSION OF SECONDARY PAYER RE-
20 QUIREMENTS FOR ESRD BENEFICIARIES.—Section
21 1862(b)(1)(C) of such Act (42 U.S.C.
22 1395y(b)(1)(C)) is amended by adding at the end
23 the following new sentence: "With regard to im-
24 munosuppressive drugs furnished on or after the
25 date of the enactment of the America's Affordable

1 Health Choices Act of 2009, this subparagraph shall
2 be applied without regard to any time limitation.''.
3 (b) MEDICARE COVERAGE FOR ESRD PATIENTS.—
4 Section 1881 of such Act is further amended—
5 (1) in subsection (b)(14)(B)(iii), by inserting '',
6 including oral drugs that are not the oral equivalent
7 of an intravenous drug (such as oral phosphate bind-
8 ers and calcimimetics),'' after ''other drugs and
9 biologicals'';
10 (2) in subsection (b)(14)(E)(ii)—
11 (A) in the first sentence—
12 (i) by striking ''a one-time election to
13 be excluded from the phase-in'' and insert-
14 ing ''an election, with respect to 2011,
15 2012, or 2013, to be excluded from the
16 phase-in (or the remainder of the phase-
17 in)''; and
18 (ii) by adding at the end the fol-
19 lowing: ''for such year and for each subse-
20 quent year during the phase-in described
21 in clause (i)''; and
22 (B) in the second sentence—
23 (i) by striking ''January 1, 2011'' and
24 inserting ''the first date of such year''; and

1 (ii) by inserting ''and at a time'' after
2 ''form and manner''; and
3 (3) in subsection (h)(4)(E), by striking ''lesser''
4 and inserting ''greater''.

5 **SEC. 1233. ADVANCE CARE PLANNING CONSULTATION.**

6 (a) MEDICARE.—
7 (1) IN GENERAL.—Section 1861 of the Social
8 Security Act (42 U.S.C. 1395x) is amended—
9 (A) in subsection (s)(2)—
10 (i) by striking ''and'' at the end of
11 subparagraph (DD);
12 (ii) by adding ''and'' at the end of
13 subparagraph (EE); and
14 (iii) by adding at the end the fol-
15 lowing new subparagraph:
16 ''(FF) advance care planning consultation (as
17 defined in subsection (hhh)(1));''; and
18 (B) by adding at the end the following new
19 subsection:
20 ''Advance Care Planning Consultation
21 ''(hhh)(1) Subject to paragraphs (3) and (4), the
22 term 'advance care planning consultation' means a con-
23 sultation between the individual and a practitioner de-
24 scribed in paragraph (2) regarding advance care planning,
25 if, subject to paragraph (3), the individual involved has

1 not had such a consultation within the last 5 years. Such
2 consultation shall include the following:
3 "(A) An explanation by the practitioner of ad-
4 vance care planning, including key questions and
5 considerations, important steps, and suggested peo-
6 ple to talk to.
7 "(B) An explanation by the practitioner of ad-
8 vance directives, including living wills and durable
9 powers of attorney, and their uses.
10 "(C) An explanation by the practitioner of the
11 role and responsibilities of a health care proxy.
12 "(D) The provision by the practitioner of a list
13 of national and State-specific resources to assist con-
14 sumers and their families with advance care plan-
15 ning, including the national toll-free hotline, the ad-
16 vance care planning clearinghouses, and State legal
17 service organizations (including those funded
18 through the Older Americans Act of 1965).
19 "(E) An explanation by the practitioner of the
20 continuum of end-of-life services and supports avail-
21 able, including palliative care and hospice, and bene-
22 fits for such services and supports that are available
23 under this title.

1 "(F)(i) Subject to clause (ii), an explanation of
2 orders regarding life sustaining treatment or similar
3 orders, which shall include—
4 "(I) the reasons why the development of
5 such an order is beneficial to the individual and
6 the individual's family and the reasons why
7 such an order should be updated periodically as
8 the health of the individual changes;
9 "(II) the information needed for an indi-
10 vidual or legal surrogate to make informed deci-
11 sions regarding the completion of such an
12 order; and
13 "(III) the identification of resources that
14 an individual may use to determine the require-
15 ments of the State in which such individual re-
16 sides so that the treatment wishes of that indi-
17 vidual will be carried out if the individual is un-
18 able to communicate those wishes, including re-
19 quirements regarding the designation of a sur-
20 rogate decisionmaker (also known as a health
21 care proxy).
22 "(ii) The Secretary shall limit the requirement
23 for explanations under clause (i) to consultations
24 furnished in a State—

1 "(I) in which all legal barriers have been
2 addressed for enabling orders for life sustaining
3 treatment to constitute a set of medical orders
4 respected across all care settings; and
5 "(II) that has in effect a program for or-
6 ders for life sustaining treatment described in
7 clause (iii).
8 "(iii) A program for orders for life sustaining
9 treatment for a States described in this clause is a
10 program that—
11 "(I) ensures such orders are standardized
12 and uniquely identifiable throughout the State;
13 "(II) distributes or makes accessible such
14 orders to physicians and other health profes-
15 sionals that (acting within the scope of the pro-
16 fessional's authority under State law) may sign
17 orders for life sustaining treatment;
18 "(III) provides training for health care
19 professionals across the continuum of care
20 about the goals and use of orders for life sus-
21 taining treatment; and
22 "(IV) is guided by a coalition of stake-
23 holders includes representatives from emergency
24 medical services, emergency department physi-
25 cians or nurses, state long-term care associa-

1 tion, state medical association, state surveyors,
2 agency responsible for senior services, state de-
3 partment of health, state hospital association,
4 home health association, state bar association,
5 and state hospice association.
6 ''(2) A practitioner described in this paragraph is—
7 ''(A) a physician (as defined in subsection
8 (r)(1)); and
9 ''(B) a nurse practitioner or physician assistant
10 who has the authority under State law to sign orders
11 for life sustaining treatments.
12 ''(3)(A) An initial preventive physical examination
13 under subsection (WW), including any related discussion
14 during such examination, shall not be considered an ad-
15 vance care planning consultation for purposes of applying
16 the 5-year limitation under paragraph (1).
17 ''(B) An advance care planning consultation with re-
18 spect to an individual may be conducted more frequently
19 than provided under paragraph (1) if there is a significant
20 change in the health condition of the individual, including
21 diagnosis of a chronic, progressive, life-limiting disease, a
22 life-threatening or terminal diagnosis or life-threatening
23 injury, or upon admission to a skilled nursing facility, a
24 long-term care facility (as defined by the Secretary), or
25 a hospice program.

1 "(4) A consultation under this subsection may in-
2 clude the formulation of an order regarding life sustaining
3 treatment or a similar order.

4 "(5)(A) For purposes of this section, the term 'order
5 regarding life sustaining treatment' means, with respect
6 to an individual, an actionable medical order relating to
7 the treatment of that individual that—

8 "(i) is signed and dated by a physician (as de-
9 fined in subsection (r)(1)) or another health care
10 professional (as specified by the Secretary and who
11 is acting within the scope of the professional's au-
12 thority under State law in signing such an order, in-
13 cluding a nurse practitioner or physician assistant)
14 and is in a form that permits it to stay with the in-
15 dividual and be followed by health care professionals
16 and providers across the continuum of care;

17 "(ii) effectively communicates the individual's
18 preferences regarding life sustaining treatment, in-
19 cluding an indication of the treatment and care de-
20 sired by the individual;

21 "(iii) is uniquely identifiable and standardized
22 within a given locality, region, or State (as identified
23 by the Secretary); and

1 "(iv) may incorporate any advance directive (as
2 defined in section 1866(f)(3)) if executed by the in-
3 dividual.
4 "(B) The level of treatment indicated under subpara-
5 graph (A)(ii) may range from an indication for full treat-
6 ment to an indication to limit some or all or specified
7 interventions. Such indicated levels of treatment may in-
8 clude indications respecting, among other items—
9 "(i) the intensity of medical intervention if the
10 patient is pulse less, apneic, or has serious cardiac
11 or pulmonary problems;
12 "(ii) the individual's desire regarding transfer
13 to a hospital or remaining at the current care set-
14 ting;
15 "(iii) the use of antibiotics; and
16 "(iv) the use of artificially administered nutri-
17 tion and hydration.".
18 (2) PAYMENT.—Section 1848(j)(3) of such Act
19 (42 U.S.C. 1395w-4(j)(3)) is amended by inserting
20 "(2)(FF)," after "(2)(EE),".
21 (3) FREQUENCY LIMITATION.—Section 1862(a)
22 of such Act (42 U.S.C. 1395y(a)) is amended—
23 (A) in paragraph (1)—
24 (i) in subparagraph (N), by striking
25 "and" at the end;

1 (ii) in subparagraph (O) by striking
2 the semicolon at the end and inserting '',
3 and''; and
4 (iii) by adding at the end the fol-
5 lowing new subparagraph:
6 ''(P) in the case of advance care planning
7 consultations (as defined in section
8 1861(hhh)(1)), which are performed more fre-
9 quently than is covered under such section;'';
10 and
11 (B) in paragraph (7), by striking ''or (K)''
12 and inserting ''(K), or (P)''.
13 (4) EFFECTIVE DATE.—The amendments made
14 by this subsection shall apply to consultations fur-
15 nished on or after January 1, 2011.
16 (b) EXPANSION OF PHYSICIAN QUALITY REPORTING
17 INITIATIVE FOR END OF LIFE CARE.—
18 (1) PHYSICIAN'S QUALITY REPORTING INITIA-
19 TIVE.—Section 1848(k)(2) of the Social Security Act
20 (42 U.S.C. 1395w–4(k)(2)) is amended by adding at
21 the end the following new paragraphs:
22 ''(3) PHYSICIAN'S QUALITY REPORTING INITIA-
23 TIVE.—
24 ''(A) IN GENERAL.—For purposes of re-
25 porting data on quality measures for covered

1 professional services furnished during 2011 and
2 any subsequent year, to the extent that meas-
3 ures are available, the Secretary shall include
4 quality measures on end of life care and ad-
5 vanced care planning that have been adopted or
6 endorsed by a consensus-based organization, if
7 appropriate. Such measures shall measure both
8 the creation of and adherence to orders for life-
9 sustaining treatment.

10 "(B) PROPOSED SET OF MEASURES.— The
11 Secretary shall publish in the Federal Register
12 proposed quality measures on end of life care
13 and advanced care planning that the Secretary
14 determines are described in subparagraph (A)
15 and would be appropriate for eligible profes-
16 sionals to use to submit data to the Secretary.
17 The Secretary shall provide for a period of pub-
18 lic comment on such set of measures before fi-
19 nalizing such proposed measures.".

20 (c) INCLUSION OF INFORMATION IN MEDICARE &
21 YOU HANDBOOK.—

22 (1) MEDICARE & YOU HANDBOOK.—

23 (A) IN GENERAL.—Not later than 1 year
24 after the date of the enactment of this Act, the
25 Secretary of Health and Human Services shall

1 update the online version of the Medicare &
2 You Handbook to include the following:
3 (i) An explanation of advance care
4 planning and advance directives, includ-
5 ing—
6 (I) living wills;
7 (II) durable power of attorney;
8 (III) orders of life-sustaining
9 treatment; and
10 (IV) health care proxies.
11 (ii) A description of Federal and State
12 resources available to assist individuals
13 and their families with advance care plan-
14 ning and advance directives, including—
15 (I) available State legal service
16 organizations to assist individuals
17 with advance care planning, including
18 those organizations that receive fund-
19 ing pursuant to the Older Americans
20 Act of 1965 (42 U.S.C. 93001 et
21 seq.);
22 (II) website links or addresses for
23 State-specific advance directive forms;
24 and

1 (III) any additional information,
2 as determined by the Secretary.
3 (B) UPDATE OF PAPER AND SUBSEQUENT
4 VERSIONS.—The Secretary shall include the in-
5 formation described in subparagraph (A) in all
6 paper and electronic versions of the Medicare &
7 You Handbook that are published on or after
8 the date that is 1 year after the date of the en-
9 actment of this Act.

10 **SEC. 1234. PART B SPECIAL ENROLLMENT PERIOD AND**
11 **WAIVER OF LIMITED ENROLLMENT PENALTY**
12 **FOR TRICARE BENEFICIARIES.**

13 (a) PART B SPECIAL ENROLLMENT PERIOD.—
14 (1) IN GENERAL.—Section 1837 of the Social
15 Security Act (42 U.S.C. 1395p) is amended by add-
16 ing at the end the following new subsection:
17 ''(l)(1) In the case of any individual who is a covered
18 beneficiary (as defined in section 1072(5) of title 10,
19 United States Code) at the time the individual is entitled
20 to hospital insurance benefits under part A under section
21 226(b) or section 226A and who is eligible to enroll but
22 who has elected not to enroll (or to be deemed enrolled)
23 during the individual's initial enrollment period, there
24 shall be a special enrollment period described in paragraph
25 (2).

1 "(2) The special enrollment period described in this
2 paragraph, with respect to an individual, is the 12-month
3 period beginning on the day after the last day of the initial
4 enrollment period of the individual or, if later, the 12-
5 month period beginning with the month the individual is
6 notified of enrollment under this section.

7 "(3) In the case of an individual who enrolls during
8 the special enrollment period provided under paragraph
9 (1), the coverage period under this part shall begin on the
10 first day of the month in which the individual enrolls or,
11 at the option of the individual, on the first day of the sec-
12 ond month following the last month of the individual's ini-
13 tial enrollment period.

14 "(4) The Secretary of Defense shall establish a meth-
15 od for identifying individuals described in paragraph (1)
16 and providing notice to them of their eligibility for enroll-
17 ment during the special enrollment period described in
18 paragraph (2).".

19 (2) EFFECTIVE DATE.—The amendment made
20 by paragraph (1) shall apply to elections made on or
21 after the date of the enactment of this Act.

22 (b) WAIVER OF INCREASE OF PREMIUM.—

23 (1) IN GENERAL.—Section 1839(b) of the So-
24 cial Security Act (42 U.S.C. 1395r(b)) is amended

1 by striking "section 1837(i)(4)" and inserting "sub-
2 section (i)(4) or (l) of section 1837".
3 (2) EFFECTIVE DATE.—
4 (A) IN GENERAL.—The amendment made
5 by paragraph (1) shall apply with respect to
6 elections made on or after the date of the en-
7 actment of this Act.
8 (B) REBATES FOR CERTAIN DISABLED
9 AND ESRD BENEFICIARIES.—
10 (i) IN GENERAL.—With respect to
11 premiums for months on or after January
12 2005 and before the month of the enact-
13 ment of this Act, no increase in the pre-
14 mium shall be effected for a month in the
15 case of any individual who is a covered
16 beneficiary (as defined in section 1072(5)
17 of title 10, United States Code) at the time
18 the individual is entitled to hospital insur-
19 ance benefits under part A of title XVIII
20 of the Social Security Act under section
21 226(b) or 226A of such Act, and who is el-
22 igible to enroll, but who has elected not to
23 enroll (or to be deemed enrolled), during
24 the individual's initial enrollment period,
25 and who enrolls under this part within the

1 12-month period that begins on the first
2 day of the month after the month of notifi-
3 cation of entitlement under this part.
4 (ii) CONSULTATION WITH DEPART-
5 MENT OF DEFENSE.—The Secretary of
6 Health and Human Services shall consult
7 with the Secretary of Defense in identi-
8 fying individuals described in this para-
9 graph.
10 (iii) REBATES.—The Secretary of
11 Health and Human Services shall establish
12 a method for providing rebates of premium
13 increases paid for months on or after Jan-
14 uary 1, 2005, and before the month of the
15 enactment of this Act for which a penalty
16 was applied and collected.

17 **SEC. 1235. EXCEPTION FOR USE OF MORE RECENT TAX**
18 **YEAR IN CASE OF GAINS FROM SALE OF PRI-**
19 **MARY RESIDENCE IN COMPUTING PART B IN-**
20 **COME-RELATED PREMIUM.**

21 (a) IN GENERAL.—Section 1839(i)(4)(C)(ii)(II) of
22 the Social Security Act (42 U.S.C. 1395r(i)(4)(C)(ii)(II))
23 is amended by inserting ‘‘sale of primary residence,’’ after
24 ‘‘divorce of such individual,’’.

1 (b) EFFECTIVE DATE.—The amendment made by
2 subsection (a) shall apply to premiums and payments for
3 years beginning with 2011.

4 **SEC. 1236. DEMONSTRATION PROGRAM ON USE OF PA-**
5 **TIENT DECISIONS AIDS.**

6 (a) IN GENERAL.—The Secretary of Health and
7 Human Services shall establish a shared decision making
8 demonstration program (in this subsection referred to as
9 the ''program'') under the Medicare program using pa-
10 tient decision aids to meet the objective of improving the
11 understanding by Medicare beneficiaries of their medical
12 treatment options, as compared to comparable Medicare
13 beneficiaries who do not participate in a shared decision
14 making process using patient decision aids.

15 (b) SITES.—

16 (1) ENROLLMENT.—The Secretary shall enroll
17 in the program not more than 30 eligible providers
18 who have experience in implementing, and have in-
19 vested in the necessary infrastructure to implement,
20 shared decision making using patient decision aids.

21 (2) APPLICATION.—An eligible provider seeking
22 to participate in the program shall submit to the
23 Secretary an application at such time and containing
24 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

1 making payments for such counseling visits provided
2 to Medicare beneficiaries under the program. Such
3 procedures shall provide for the establishment—
4 (A) of a code (or codes) to represent such
5 services; and
6 (B) of a single payment amount for such
7 service that includes the professional time of
8 the health care provider and a portion of the
9 reasonable costs of the infrastructure of the eli-
10 gible provider such as would be made under the
11 applicable payment systems to that provider for
12 similar covered services.
13 (d) COSTS OF AIDS.—An eligible provider partici-
14 pating in the program shall be responsible for the costs
15 of selecting, purchasing, and incorporating such patient
16 decision aids into the provider's practice, and reporting
17 data on quality and outcome measures under the program.
18 (e) FUNDING.—The Secretary shall provide for the
19 transfer from the Federal Supplementary Medical Insur-
20 ance Trust Fund established under section 1841 of the
21 Social Security Act (42 U.S.C. 1395t) of such funds as
22 are necessary for the costs of carrying out the program.
23 (f) WAIVER AUTHORITY.—The Secretary may waive
24 such requirements of titles XI and XVIII of the Social
25 Security Act (42 U.S.C. 1301 et seq. and 1395 et seq.)

1 as may be necessary for the purpose of carrying out the
2 program.
3 (g) REPORT.—Not later than 12 months after the
4 date of completion of the program, the Secretary shall sub-
5 mit to Congress a report on such program, together with
6 recommendations for such legislation and administrative
7 action as the Secretary determines to be appropriate. The
8 final report shall include an evaluation of the impact of
9 the use of the program on health quality, utilization of
10 health care services, and on improving the quality of life
11 of such beneficiaries.
12 (h) DEFINITIONS.—In this section:
13 (1) ELIGIBLE PROVIDER.—The term "eligible
14 provider" means the following:
15 (A) A primary care practice.
16 (B) A specialty practice.
17 (C) A multispecialty group practice.
18 (D) A hospital.
19 (E) A rural health clinic.
20 (F) A Federally qualified health center (as
21 defined in section 1861(aa)(4) of the Social Se-
22 curity Act (42 U.S.C. 1395x(aa)(4)).
23 (G) An integrated delivery system.
24 (H) A State cooperative entity that in-
25 cludes the State government and at least one

1 other health care provider which is set up for
2 the purpose of testing shared decision making
3 and patient decision aids.
4 (2) PATIENT DECISION AID.—The term "pa-
5 tient decision aid" means an educational tool (such
6 as the Internet, a video, or a pamphlet) that helps
7 patients (or, if appropriate, the family caregiver of
8 the patient) understand and communicate their be-
9 liefs and preferences related to their treatment op-
10 tions, and to decide with their health care provider
11 what treatments are best for them based on their
12 treatment options, scientific evidence, circumstances,
13 beliefs, and preferences.
14 (3) SHARED DECISION MAKING.—The term
15 "shared decision making" means a collaborative
16 process between patient and clinician that engages
17 the patient in decision making, provides patients
18 with information about trade-offs among treatment
19 options, and facilitates the incorporation of patient
20 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

1 "(3) reward physician practices and other phy-
2 sician organizational models for the provision of high
3 quality and efficient health care services.
4 "(b) QUALIFYING ACCOUNTABLE CARE ORGANIZA-
5 TIONS (ACOS).—
6 "(1) QUALIFYING ACO DEFINED.—In this sec-
7 tion:
8 "(A) IN GENERAL.—The terms 'qualifying
9 accountable care organization' and 'qualifying
10 ACO' mean a group of physicians or other phy-
11 sician organizational model (as defined in sub-
12 paragraph (D)) that—
13 "(i) is organized at least in part for
14 the purpose of providing physicians' serv-
15 ices; and
16 "(ii) meets such criteria as the Sec-
17 retary determines to be appropriate to par-
18 ticipate in the pilot program, including the
19 criteria specified in paragraph (2).
20 "(B) INCLUSION OF OTHER PROVIDERS.—
21 Nothing in this subsection shall be construed as
22 preventing a qualifying ACO from including a
23 hospital or any other provider of services or
24 supplier furnishing items or services for which
25 payment may be made under this title that is

1 affiliated with the ACO under an arrangement
2 structured so that such provider or supplier
3 participates in the pilot program and shares in
4 any incentive payments under the pilot pro-
5 gram.

6 ''(C) PHYSICIAN.—The term 'physician' in-
7 cludes, except as the Secretary may otherwise
8 provide, any individual who furnishes services
9 for which payment may be made as physicians'
10 services.

11 ''(D) OTHER PHYSICIAN ORGANIZATIONAL
12 MODEL.—The term 'other physician organiza-
13 tion model' means, with respect to a qualifying
14 ACO any model of organization under which
15 physicians enter into agreements with other
16 providers for the purposes of participation in
17 the pilot program in order to provide high qual-
18 ity and efficient health care services and share
19 in any incentive payments under such program

20 ''(E) OTHER SERVICES.—Nothing in this
21 paragraph shall be construed as preventing a
22 qualifying ACO from furnishing items or serv-
23 ices, for which payment may not be made under
24 this title, for purposes of achieving performance
25 goals under the pilot program.

1 "(2) QUALIFYING CRITERIA.—The following are
2 criteria described in this paragraph for an organized
3 group of physicians to be a qualifying ACO:
4 "(A) The group has a legal structure that
5 would allow the group to receive and distribute
6 incentive payments under this section.
7 "(B) The group includes a sufficient num-
8 ber of primary care physicians (regardless of
9 specialty) for the applicable beneficiaries for
10 whose care the group is accountable (as deter-
11 mined by the Secretary).
12 "(C) The group reports on quality meas-
13 ures in such form, manner, and frequency as
14 specified by the Secretary (which may be for
15 the group, for providers of services and sup-
16 pliers, or both).
17 "(D) The group reports to the Secretary
18 (in a form, manner and frequency as specified
19 by the Secretary) such data as the Secretary
20 determines appropriate to monitor and evaluate
21 the pilot program.
22 "(E) The group provides notice to applica-
23 ble beneficiaries regarding the pilot program (as
24 determined appropriate by the Secretary).

1 "(F) The group contributes to a best prac-
2 tices network or website, that shall be main-
3 tained by the Secretary for the purpose of shar-
4 ing strategies on quality improvement, care co-
5 ordination, and efficiency that the groups be-
6 lieve are effective.

7 "(G) The group utilizes patient-centered
8 processes of care, including those that empha-
9 size patient and caregiver involvement in plan-
10 ning and monitoring of ongoing care manage-
11 ment plan.

12 "(H) The group meets other criteria deter-
13 mined to be appropriate by the Secretary.

14 "(c) SPECIFIC PAYMENT INCENTIVE MODELS.—The
15 specific payment incentive models described in this sub-
16 section are the following:

17 "(1) PERFORMANCE TARGET MODEL.—Under
18 the performance target model under this paragraph
19 (in this paragraph referred to as the 'performance
20 target model'):

21 "(A) IN GENERAL.—A qualifying ACO
22 qualifies to receive an incentive payment if ex-
23 penditures for applicable beneficiaries are less
24 than a target spending level or a target rate of
25 growth. The incentive payment shall be made

1 only if savings are greater than would result
2 from normal variation in expenditures for items
3 and services covered under parts A and B.

4 "(B) COMPUTATION OF PERFORMANCE
5 TARGET.—

6 "(i) IN GENERAL.—The Secretary
7 shall establish a performance target for
8 each qualifying ACO comprised of a base
9 amount (described in clause (ii)) increased
10 to the current year by an adjustment fac-
11 tor (described in clause (iii)). Such a tar-
12 get may be established on a per capita
13 basis, as the Secretary determines to be
14 appropriate.

15 "(ii) BASE AMOUNT.—For purposes of
16 clause (i), the base amount in this sub-
17 paragraph is equal to the average total
18 payments (or allowed charges) under parts
19 A and B (and may include part D, if the
20 Secretary determines appropriate) for ap-
21 plicable beneficiaries for whom the quali-
22 fying ACO furnishes items and services in
23 a base period determined by the Secretary.
24 Such base amount may be determined on
25 a per capita basis.

1 "(iii) ADJUSTMENT FACTOR.—For
2 purposes of clause (i), the adjustment fac-
3 tor in this clause may equal an annual per
4 capita amount that reflects changes in ex-
5 penditures from the period of the base
6 amount to the current year that would rep-
7 resent an appropriate performance target
8 for applicable beneficiaries (as determined
9 by the Secretary). Such adjustment factor
10 may be determined as an amount or rate,
11 may be determined on a national, regional,
12 local, or organization-specific basis, and
13 may be determined on a per capita basis.
14 Such adjustment factor also may be ad-
15 justed for risk as determined appropriate
16 by the Secretary.

17 "(iv) REBASING.—Under this model
18 the Secretary shall periodically rebase the
19 base expenditure amount described in
20 clause (ii).

21 "(C) MEETING TARGET.—

22 "(i) IN GENERAL.—Subject to clause
23 (ii), a qualifying ACO that meet or exceeds
24 annual quality and performance targets for
25 a year shall receive an incentive payment

1 for such year equal to a portion (as deter-
2 mined appropriate by the Secretary) of the
3 amount by which payments under this title
4 for such year relative are estimated to be
5 below the performance target for such
6 year, as determined by the Secretary. The
7 Secretary may establish a cap on incentive
8 payments for a year for a qualifying ACO.
9 ''(ii) LIMITATION.— The Secretary
10 shall limit incentive payments to each
11 qualifying ACO under this paragraph as
12 necessary to ensure that the aggregate ex-
13 penditures with respect to applicable bene-
14 ficiaries for such ACOs under this title (in-
15 clusive of incentive payments described in
16 this subparagraph) do not exceed the
17 amount that the Secretary estimates would
18 be expended for such ACO for such bene-
19 ficiaries if the pilot program under this
20 section were not implemented.
21 ''(D) REPORTING AND OTHER REQUIRE-
22 MENTS.—In carrying out such model, the Sec-
23 retary may (as the Secretary determines to be
24 appropriate) incorporate reporting require-
25 ments, incentive payments, and penalties re-

1 lated to the physician quality reporting initia-
2 tive (PQRI), electronic prescribing, electronic
3 health records, and other similar initiatives
4 under section 1848, and may use alternative
5 criteria than would otherwise apply under such
6 section for determining whether to make such
7 payments. The incentive payments described in
8 this subparagraph shall not be included in the
9 limit described in subparagraph (C)(ii) or in the
10 performance target model described in this
11 paragraph.

12 ''(2) PARTIAL CAPITATION MODEL.—

13 ''(A) IN GENERAL.—Subject to subpara-
14 graph (B), a partial capitation model described
15 in this paragraph (in this paragraph referred to
16 as a 'partial capitation model') is a model in
17 which a qualifying ACO would be at financial
18 risk for some, but not all, of the items and serv-
19 ices covered under parts A and B, such as at
20 risk for some or all physicians' services or all
21 items and services under part B. The Secretary
22 may limit a partial capitation model to ACOs
23 that are highly integrated systems of care and
24 to ACOs capable of bearing risk, as determined
25 to be appropriate by the Secretary.

1 "(B) NO ADDITIONAL PROGRAM EXPENDI-
2 TURES.—Payments to a qualifying ACO for ap-
3 plicable beneficiaries for a year under the par-
4 tial capitation model shall be established in a
5 manner that does not result in spending more
6 for such ACO for such beneficiaries than would
7 otherwise be expended for such ACO for such
8 beneficiaries for such year if the pilot program
9 were not implemented, as estimated by the Sec-
10 retary.
11 "(3) OTHER PAYMENT MODELS.—
12 "(A) IN GENERAL.—Subject to subpara-
13 graph (B), the Secretary may develop other
14 payment models that meet the goals of this
15 pilot program to improve quality and efficiency.
16 "(B) NO ADDITIONAL PROGRAM EXPENDI-
17 TURES.—Subparagraph (B) of paragraph (2)
18 shall apply to a payment model under subpara-
19 graph (A) in a similar manner as such subpara-
20 graph (B) applies to the payment model under
21 paragraph (2).
22 "(d) APPLICABLE BENEFICIARIES.—
23 "(1) IN GENERAL.—In this section, the term
24 'applicable beneficiary' means, with respect to a
25 qualifying ACO, an individual who—

1 ‘‘(A) is enrolled under part B and entitled
2 to benefits under part A;
3 ‘‘(B) is not enrolled in a Medicare Advan-
4 tage plan under part C or a PACE program
5 under section 1894; and
6 ‘‘(C) meets such other criteria as the Sec-
7 retary determines appropriate, which may in-
8 clude criteria relating to frequency of contact
9 with physicians in the ACO
10 ‘‘(2) FOLLOWING APPLICABLE BENE-
11 FICIARIES.—The Secretary may monitor data on ex-
12 penditures and quality of services under this title
13 after an applicable beneficiary discontinues receiving
14 services under this title through a qualifying ACO.
15 ‘‘(e) IMPLEMENTATION.—
16 ‘‘(1) STARTING DATE.—The pilot program shall
17 begin no later than January 1, 2012. An agreement
18 with a qualifying ACO under the pilot program may
19 cover a multi-year period of between 3 and 5 years.
20 ‘‘(2) WAIVER.—The Secretary may waive such
21 provisions of this title (including section 1877) and
22 title XI in the manner the Secretary determines nec-
23 essary in order implement the pilot program.
24 ‘‘(3) PERFORMANCE RESULTS REPORTS.—The
25 Secretary shall report performance results to quali-

1 fying ACOs under the pilot program at least annu-
2 ally.
3 "(4) LIMITATIONS ON REVIEW.—There shall be
4 no administrative or judicial review under section
5 1869, section 1878, or otherwise of—
6 "(A) the elements, parameters, scope, and
7 duration of the pilot program;
8 "(B) the selection of qualifying ACOs for
9 the pilot program;
10 "(C) the establishment of targets, meas-
11 urement of performance, determinations with
12 respect to whether savings have been achieved
13 and the amount of savings;
14 "(D) determinations regarding whether, to
15 whom, and in what amounts incentive payments
16 are paid; and
17 "(E) decisions about the extension of the
18 program under subsection (g), expansion of the
19 program under subsection (h) or extensions
20 under subsection (i).
21 "(5) ADMINISTRATION.—Chapter 35 of title 44,
22 United States Code shall not apply to this section.
23 "(f) EVALUATION; MONITORING.—
24 "(1) IN GENERAL.—The Secretary shall evalu-
25 ate the payment incentive model for each qualifying

1 ACO under the pilot program to assess impacts on
2 beneficiaries, providers of services, suppliers and the
3 program under this title. The Secretary shall make
4 such evaluation publicly available within 60 days of
5 the date of completion of such report.

6 "(2) MONITORING.—The Inspector General of
7 the Department of Health and Human Services shall
8 provide for monitoring of the operation of ACOs
9 under the pilot program with regard to violations of
10 section 1877 (popularly known as the 'Stark law').

11 "(g) EXTENSION OF PILOT AGREEMENT WITH SUC-
12 CESSFUL ORGANIZATIONS.—

13 "(1) REPORTS TO CONGRESS.—Not later than
14 2 years after the date the first agreement is entered
15 into under this section, and biennially thereafter for
16 six years, the Secretary shall submit to Congress
17 and make publicly available a report on the use of
18 authorities under the pilot program. Each report
19 shall address the impact of the use of those authori-
20 ties on expenditures, access, and quality under this
21 title.

22 "(2) EXTENSION.—Subject to the report pro-
23 vided under paragraph (1), with respect to a quali-
24 fying ACO, the Secretary may extend the duration

1 of the agreement for such ACO under the pilot pro-
2 gram as the Secretary determines appropriate if—
3 ''(A) the ACO receives incentive payments
4 with respect to any of the first 4 years of the
5 pilot agreement and is consistently meeting
6 quality standards or
7 ''(B) the ACO is consistently exceeding
8 quality standards and is not increasing spend-
9 ing under the program.
10 ''(3) TERMINATION.—The Secretary may termi-
11 nate an agreement with a qualifying ACO under the
12 pilot program if such ACO did not receive incentive
13 payments or consistently failed to meet quality
14 standards in any of the first 3 years under the pro-
15 gram.
16 ''(h) EXPANSION TO ADDITIONAL ACOS.—
17 ''(1) TESTING AND REFINEMENT OF PAYMENT
18 INCENTIVE MODELS.—Subject to the evaluation de-
19 scribed in subsection (f), the Secretary may enter
20 into agreements under the pilot program with addi-
21 tional qualifying ACOs to further test and refine
22 payment incentive models with respect to qualifying
23 ACOs.
24 ''(2) EXPANDING USE OF SUCCESSFUL MODELS
25 TO PROGRAM IMPLEMENTATION.—

1 "(A) IN GENERAL.—Subject to subpara-
2 graph (B), the Secretary may issue regulations
3 to implement, on a permanent basis, 1 or more
4 models if, and to the extent that, such models
5 are beneficial to the program under this title, as
6 determined by the Secretary.
7 "(B) CERTIFICATION.—The Chief Actuary
8 of the Centers for Medicare & Medicaid Serv-
9 ices shall certify that 1 or more of such models
10 described in subparagraph (A) would result in
11 estimated spending that would be less than
12 what spending would otherwise be estimated to
13 be in the absence of such expansion.
14 "(i) TREATMENT OF PHYSICIAN GROUP PRACTICE
15 DEMONSTRATION.—
16 "(1) EXTENSION.—The Secretary may enter in
17 to an agreement with a qualifying ACO under the
18 demonstration under section 1866A, subject to re-
19 basing and other modifications deemed appropriate
20 by the Secretary, until the pilot program under this
21 section is operational.
22 "(2) TRANSITION.—For purposes of extension
23 of an agreement with a qualifying ACO under sub-
24 section (g)(2), the Secretary shall treat receipt of an
25 incentive payment for a year by an organization

1 under the physician group practice demonstration
2 pursuant to section 1866A as a year for which an
3 incentive payment is made under such subsection, as
4 long as such practice group practice organization
5 meets the criteria under subsection (b)(2).
6 "(j) ADDITIONAL PROVISIONS.—
7 "(1) AUTHORITY FOR SEPARATE INCENTIVE
8 ARRANGEMENTS.—The Secretary may create sepa-
9 rate incentive arrangements (including using mul-
10 tiple years of data, varying thresholds, varying
11 shared savings amounts, and varying shared savings
12 limits) for different categories of qualifying ACOs to
13 reflect natural variations in data availability, vari-
14 ation in average annual attributable expenditures,
15 program integrity, and other matters the Secretary
16 deems appropriate.
17 "(2) ENCOURAGEMENT OF PARTICIPATION OF
18 SMALLER ORGANIZATIONS.—In order to encourage
19 the participation of smaller accountable care organi-
20 zations under the pilot program, the Secretary may
21 limit a qualifying ACO's exposure to high cost pa-
22 tients under the program.
23 "(3) INVOLVEMENT IN PRIVATE PAYER AR-
24 RANGEMENTS.—Nothing in this section shall be con-
25 strued as preventing qualifying ACOs participating

1 in the pilot program from negotiating similar con-
2 tracts with private payers.
3 ''(4) ANTIDISCRIMINATION LIMITATION.—The
4 Secretary shall not enter into an agreement with an
5 entity to provide health care items or services under
6 the pilot program, or with an entity to administer
7 the program, unless such entity guarantees that it
8 will not deny, limit, or condition the coverage or pro-
9 vision of benefits under the program, for individuals
10 eligible to be enrolled under such program, based on
11 any health status-related factor described in section
12 2702(a)(1) of the Public Health Service Act.
13 ''(5) CONSTRUCTION.—Nothing in this section
14 shall be construed to compel or require an organiza-
15 tion to use an organization-specific target growth
16 rate for an accountable care organization under this
17 section for purposes of section 1848.
18 ''(6) FUNDING.—For purposes of administering
19 and carrying out the pilot program, other than for
20 payments for items and services furnished under this
21 title and incentive payments under subsection (c)(1),
22 in addition to funds otherwise appropriated, there
23 are appropriated to the Secretary for the Center for
24 Medicare & Medicaid Services Program Management
25 Account $25,000,000 for each of fiscal years 2010

1 through 2014 and $20,000,000 for fiscal year 2015.
2 Amounts appropriated under this paragraph for a
3 fiscal year shall be available until expended.''.

4 **SEC. 1302. MEDICAL HOME PILOT PROGRAM.**

5 (a) IN GENERAL.—Title XVIII of the Social Security
6 Act is amended by inserting after section 1866D, as in-
7 serted by section 1301, the following new section:

8 ''MEDICAL HOME PILOT PROGRAM

9 ''SEC. 1866E. (a) ESTABLISHMENT AND MEDICAL
10 HOME MODELS.—

11 ''(1) ESTABLISHMENT OF PILOT PROGRAM.—
12 The Secretary shall establish a medical home pilot
13 program (in this section referred to as the 'pilot pro-
14 gram') for the purpose of evaluating the feasibility
15 and advisability of reimbursing qualified patient-cen-
16 tered medical homes for furnishing medical home
17 services (as defined under subsection (b)(1)) to high
18 need beneficiaries (as defined in subsection
19 (d)(1)(C)) and to targeted high need beneficiaries
20 (as defined in subsection (c)(1)(C)).

21 ''(2) SCOPE.—Subject to subsection (g), the
22 pilot program shall include urban, rural, and under-
23 served areas.

24 ''(3) MODELS OF MEDICAL HOMES IN THE
25 PILOT PROGRAM.—The pilot program shall evaluate
26 each of the following medical home models:

1 "(A) INDEPENDENT PATIENT-CENTERED
2 MEDICAL HOME MODEL.—Independent patient-
3 centered medical home model under subsection
4 (c).
5 "(B) COMMUNITY-BASED MEDICAL HOME
6 MODEL.—Community-based medical home
7 model under subsection (d).
8 "(4) PARTICIPATION OF NURSE PRACTITIONERS
9 AND PHYSICIAN ASSISTANTS.—
10 "(A) Nothing in this section shall be con-
11 strued as preventing a nurse practitioner from
12 leading a patient centered medical home so long
13 as—
14 "(i) all the requirements of this sec-
15 tion are met; and
16 "(ii) the nurse practitioner is acting
17 consistently with State law.
18 "(B) Nothing in this section shall be con-
19 strued as preventing a physician assistant from
20 participating in a patient centered medical
21 home so long as—
22 "(i) all the requirements of this sec-
23 tion are met; and
24 "(ii) the physician assistant is acting
25 consistently with State law.

1 “(b) DEFINITIONS.—For purposes of this section:
2 “(1) PATIENT-CENTERED MEDICAL HOME
3 SERVICES.—The term ‘patient-centered medical
4 home services’ means services that—
5 “(A) provide beneficiaries with direct and
6 ongoing access to a primary care or principal
7 care by a physician or nurse practitioner who
8 accepts responsibility for providing first contact,
9 continuous and comprehensive care to such ben-
10 eficiary;
11 “(B) coordinate the care provided to a ben-
12 eficiary by a team of individuals at the practice
13 level across office, institutional and home set-
14 tings led by a primary care or principal care
15 physician or nurse practitioner, as needed and
16 appropriate;
17 “(C) provide for all the patient’s health
18 care needs or take responsibility for appro-
19 priately arranging care with other qualified pro-
20 viders for all stages of life;
21 “(D) provide continuous access to care and
22 communication with participating beneficiaries;
23 “(E) provide support for patient self-man-
24 agement, proactive and regular patient moni-
25 toring, support for family caregivers, use pa-

1 tient-centered processes, and coordination with
2 community resources;
3 ‘‘(F) integrate readily accessible, clinically
4 useful information on participating patients
5 that enables the practice to treat such patients
6 comprehensively and systematically; and
7 ‘‘(G) implement evidence-based guidelines
8 and apply such guidelines to the identified
9 needs of beneficiaries over time and with the in-
10 tensity needed by such beneficiaries.
11 ‘‘(2) PRIMARY CARE.—The term ‘primary care’
12 means health care that is provided by a physician,
13 nurse practitioner, or physician assistant who prac-
14 tices in the field of family medicine, general internal
15 medicine, geriatric medicine, or pediatric medicine.
16 ‘‘(3) PRINCIPAL CARE.—The term ‘principal
17 care’ means integrated, accessible health care that is
18 provided by a physician who is a medical sub-
19 specialist that addresses the majority of the personal
20 health care needs of patients with chronic conditions
21 requiring the subspecialist’s expertise, and for whom
22 the subspecialist assumes care management.
23 ‘‘(c) INDEPENDENT PATIENT-CENTERED MEDICAL
24 HOME MODEL.—
25 ‘‘(1) IN GENERAL.—

1 "(A) PAYMENT AUTHORITY.—Under the
2 independent patient-centered medical home
3 model under this subsection, the Secretary shall
4 make payments for medical home services fur-
5 nished by an independent patient-centered med-
6 ical home (as defined in subparagraph (B))
7 pursuant to paragraph (3)(B) for a targeted
8 high need beneficiaries (as defined in subpara-
9 graph (C)).
10 "(B) INDEPENDENT PATIENT-CENTERED
11 MEDICAL HOME DEFINED.—In this section, the
12 term 'independent patient-centered medical
13 home' means a physician-directed or nurse-
14 practitioner-directed practice that is qualified
15 under paragraph (2) as—
16 "(i) providing beneficiaries with pa-
17 tient-centered medical home services; and
18 "(ii) meets such other requirements as
19 the Secretary may specify.
20 "(C) TARGETED HIGH NEED BENEFICIARY
21 DEFINED.—For purposes of this subsection, the
22 term 'targeted high need beneficiary' means a
23 high need beneficiary who, based on a risk score
24 as specified by the Secretary, is generally within

1 the upper 50th percentile of Medicare bene-
2 ficiaries.
3 "(D) BENEFICIARY ELECTION TO PARTICI-
4 PATE.—The Secretary shall determine an ap-
5 propriate method of ensuring that beneficiaries
6 have agreed to participate in the pilot program.
7 "(E) IMPLEMENTATION.—The pilot pro-
8 gram under this subsection shall begin no later
9 than 6 months after the date of the enactment
10 of this section.
11 "(2) STANDARD SETTING AND QUALIFICATION
12 PROCESS FOR PATIENT-CENTERED MEDICAL
13 HOMES.—The Secretary shall review alternative
14 models for standard setting and qualification, and
15 shall establish a process—
16 "(A) to establish standards to enable med-
17 ical practices to qualify as patient-centered
18 medical homes; and
19 "(B) to initially provide for the review and
20 certification of medical practices as meeting
21 such standards.
22 "(3) PAYMENT.—
23 "(A) ESTABLISHMENT OF METHOD-
24 OLOGY.—The Secretary shall establish a meth-
25 odology for the payment for medical home serv-

1 ices furnished by independent patient-centered
2 medical homes. Under such methodology, the
3 Secretary shall adjust payments to medical
4 homes based on beneficiary risk scores to en-
5 sure that higher payments are made for higher
6 risk beneficiaries.
7 "(B) PER BENEFICIARY PER MONTH PAY-
8 MENTS.—Under such payment methodology, the
9 Secretary shall pay independent patient-cen-
10 tered medical homes a monthly fee for each tar-
11 geted high need beneficiary who consents to re-
12 ceive medical home services through such med-
13 ical home.
14 "(C) PROSPECTIVE PAYMENT.—The fee
15 under subparagraph (B) shall be paid on a pro-
16 spective basis.
17 "(D) AMOUNT OF PAYMENT.—In deter-
18 mining the amount of such fee, the Secretary
19 shall consider the following:
20 "(i) The clinical work and practice ex-
21 penses involved in providing the medical
22 home services provided by the independent
23 patient-centered medical home (such as
24 providing increased access, care coordina-
25 tion, population disease management, and

1 teaching self-care skills for managing
2 chronic illnesses) for which payment is not
3 made under this title as of the date of the
4 enactment of this section.

5 ''(ii) Allow for differential payments
6 based on capabilities of the independent
7 patient-centered medical home.

8 ''(iii) Use appropriate risk-adjustment
9 in determining the amount of the per bene-
10 ficiary per month payment under this
11 paragraph in a manner that ensures that
12 higher payments are made for higher risk
13 beneficiaries.

14 ''(4) ENCOURAGING PARTICIPATION OF VARI-
15 ETY OF PRACTICES.—The pilot program under this
16 subsection shall be designed to include the participa-
17 tion of physicians in practices with fewer than 10
18 full-time equivalent physicians, as well as physicians
19 in larger practices, particularly in underserved and
20 rural areas, as well as federally qualified community
21 health centers, and rural health centers.

22 ''(5) NO DUPLICATION IN PILOT PARTICIPA-
23 TION.—A physician in a group practice that partici-
24 pates in the accountable care organization pilot pro-
25 gram under section 1866D shall not be eligible to

1 participate in the pilot program under this sub-
2 section, unless the pilot program under this section
3 has been implemented on a permanent basis under
4 subsection (e)(3).
5 "(d) COMMUNITY-BASED MEDICAL HOME MODEL.—
6 "(1) IN GENERAL.—
7 "(A) AUTHORITY FOR PAYMENTS.—Under
8 the community-based medical home model
9 under this subsection (in this section referred to
10 as the 'CBMH model'), the Secretary shall
11 make payments for the furnishing of medical
12 home services by a community-based medical
13 home (as defined in subparagraph (B)) pursu-
14 ant to paragraph (5)(B) for high need bene-
15 ficiaries.
16 "(B) COMMUNITY-BASED MEDICAL HOME
17 DEFINED.—In this section, the term 'commu-
18 nity-based medical home' means a nonprofit
19 community-based or State-based organization
20 that is certified under paragraph (2) as meeting
21 the following requirements:
22 "(i) The organization provides bene-
23 ficiaries with medical home services.
24 "(ii) The organization provides med-
25 ical home services under the supervision of

1 and in close collaboration with the primary
2 care or principal care physician, nurse
3 practitioner, or physician assistant des-
4 ignated by the beneficiary as his or her
5 community-based medical home provider.
6 ''(iii) The organization employs com-
7 munity health workers, including nurses or
8 other non-physician practitioners, lay
9 health workers, or other persons as deter-
10 mined appropriate by the Secretary, that
11 assist the primary or principal care physi-
12 cian, nurse practitioner, or physician as-
13 sistant in chronic care management activi-
14 ties such as teaching self-care skills for
15 managing chronic illnesses, transitional
16 care services, care plan setting, medication
17 therapy management services for patients
18 with multiple chronic diseases, or help
19 beneficiaries access the health care and
20 community-based resources in their local
21 geographic area.
22 ''(iv) The organization meets such
23 other requirements as the Secretary may
24 specify.

1 "(C) HIGH NEED BENEFICIARY.—In this
2 section, the term 'high need beneficiary' means
3 an individual who requires regular medical
4 monitoring, advising, or treatment.
5 "(2) QUALIFICATION PROCESS FOR COMMU-
6 NITY-BASED MEDICAL HOMES.—The Secretary shall
7 establish a process—
8 "(A) for the initial qualification of commu-
9 nity-based or State-based organizations as com-
10 munity-based medical homes; and
11 "(B) to provide for the review and quali-
12 fication of such community-based and State-
13 based organizations pursuant to criteria estab-
14 lished by the Secretary.
15 "(3) DURATION.—The pilot program for com-
16 munity-based medical homes under this subsection
17 shall start no later than 2 years after the date of the
18 enactment of this section. Each demonstration site
19 under the pilot program shall operate for a period
20 of up to 5 years after the initial implementation
21 phase, without regard to the receipt of a initial im-
22 plementation funding under subsection (i).
23 "(4) PREFERENCE.—In selecting sites for the
24 CBMH model, the Secretary may give preference
25 to—

1 "(A) applications from geographic areas
2 that propose to coordinate health care services
3 for chronically ill beneficiaries across a variety
4 of health care settings, such as primary care
5 physician practices with fewer than 10 physi-
6 cians, specialty physicians, nurse practitioner
7 practices, Federally qualified health centers,
8 rural health clinics, and other settings;
9 "(B) applications that include other payors
10 that furnish medical home services for chron-
11 ically ill patients covered by such payors; and
12 "(C) applications from States that propose
13 to use the medical home model to coordinate
14 health care services for individuals enrolled
15 under this title, individuals enrolled under title
16 XIX, and full-benefit dual eligible individuals
17 (as defined in section 1935(c)(6)) with chronic
18 diseases across a variety of health care settings.
19 "(5) PAYMENTS.—
20 "(A) ESTABLISHMENT OF METHOD-
21 OLOGY.—The Secretary shall establish a meth-
22 odology for the payment for medical home serv-
23 ices furnished under the CBMH model.
24 "(B) PER BENEFICIARY PER MONTH PAY-
25 MENTS.—Under such payment methodology, the

1 Secretary shall make two separate monthly pay-
2 ments for each high need beneficiary who con-
3 sents to receive medical home services through
4 such medical home, as follows:
5 ''(i) PAYMENT TO COMMUNITY-BASED
6 ORGANIZATION.—One monthly payment to
7 a community-based or State-based organi-
8 zation.
9 ''(ii) PAYMENT TO PRIMARY OR PRIN-
10 CIPAL CARE PRACTICE.—One monthly pay-
11 ment to the primary or principal care prac-
12 tice for such beneficiary.
13 ''(C) PROSPECTIVE PAYMENT.—The pay-
14 ments under subparagraph (B) shall be paid on
15 a prospective basis.
16 ''(D) AMOUNT OF PAYMENT.—In deter-
17 mining the amount of such payment, the Sec-
18 retary shall consider the following:
19 ''(i) The clinical work and practice ex-
20 penses involved in providing the medical
21 home services provided by the community-
22 based medical home (such as providing in-
23 creased access, care coordination, care plan
24 setting, population disease management,
25 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;

1 "(ii) improvement in reducing health
2 disparities;
3 "(iii) reductions in preventable hos-
4 pitalizations;
5 "(iv) prevention of readmissions;
6 "(v) reductions in emergency room
7 visits;
8 "(vi) improvement in health outcomes,
9 including patient functional status where
10 applicable;
11 "(vii) improvement in patient satisfac-
12 tion;
13 "(viii) improved efficiency of care such
14 as reducing duplicative diagnostic tests and
15 laboratory tests; and
16 "(ix) reductions in health care ex-
17 penditures; and
18 "(B) the feasability and advisability of re-
19 imbursing medical homes for medical home
20 services under this title on a permanent basis.
21 "(2) REPORT.—Not later than 60 days after
22 the date of completion of the evaluation under para-
23 graph (1), the Secretary shall submit to Congress
24 and make available to the public a report on the
25 findings of the evaluation under paragraph (1).

1 "(3) EXPANSION OF PROGRAM.—
2 "(A) IN GENERAL.—Subject to the results
3 of the evaluation under paragraph (1) and sub-
4 paragraph (B), the Secretary may issue regula-
5 tions to implement, on a permanent basis, one
6 or more models, if, and to the extent that such
7 model or models, are beneficial to the program
8 under this title, including that such implemen-
9 tation will improve quality of care, as deter-
10 mined by the Secretary.
11 "(B) CERTIFICATION REQUIREMENT.—The
12 Secretary may not issue such regulations unless
13 the Chief Actuary of the Centers for Medicare
14 & Medicaid Services certifies that the expansion
15 of the components of the pilot program de-
16 scribed in subparagraph (A) would result in es-
17 timated spending under this title that would be
18 no more than the level of spending that the
19 Secretary estimates would otherwise be spent
20 under this title in the absence of such expan-
21 sion.
22 "(f) ADMINISTRATIVE PROVISIONS.—
23 "(1) NO DUPLICATION IN PAYMENTS.—During
24 any month, the Secretary may not make payments
25 under this section under more than one model or

1 through more than one medical home under any
2 model for the furnishing of medical home services to
3 an individual.

4 "(2) NO EFFECT ON PAYMENT FOR EVALUA-
5 TION AND MANAGEMENT SERVICES.—Payments
6 made under this section are in addition to, and have
7 no effect on the amount of, payment for evaluation
8 and management services made under this title

9 "(3) ADMINISTRATION.—Chapter 35 of title 44,
10 United States Code shall not apply to this section.

11 "(g) FUNDING.—

12 "(1) OPERATIONAL COSTS.—For purposes of
13 administering and carrying out the pilot program
14 (including the design, implementation, technical as-
15 sistance for and evaluation of such program), in ad-
16 dition to funds otherwise available, there shall be
17 transferred from the Federal Supplementary Medical
18 Insurance Trust Fund under section 1841 to the
19 Secretary for the Centers for Medicare & Medicaid
20 Services Program Management Account $6,000,000
21 for each of fiscal years 2010 through 2014.
22 Amounts appropriated under this paragraph for a
23 fiscal year shall be available until expended.

24 "(2) PATIENT-CENTERED MEDICAL HOME
25 SERVICES.—In addition to funds otherwise available,

1 there shall be available to the Secretary for the Cen-
2 ters for Medicare & Medicaid Services, from the
3 Federal Supplementary Medical Insurance Trust
4 Fund under section 1841—
5 ‘‘(A) $200,000,000 for each of fiscal years
6 2010 through 2014 for payments for medical
7 home services under subsection (c)(3); and
8 ‘‘(B) $125,000,000 for each of fiscal years
9 2012 through 2016, for payments under sub-
10 section (d)(5).
11 Amounts available under this paragraph for a fiscal
12 year shall be available until expended.
13 ‘‘(3) INITIAL IMPLEMENTATION.—In addition
14 to funds otherwise available, there shall be available
15 to the Secretary for the Centers for Medicare &
16 Medicaid Services, from the Federal Supplementary
17 Medical Insurance Trust Fund under section 1841,
18 $2,500,000 for each of fiscal years 2010 through
19 2012, under subsection (d)(6). Amounts available
20 under this paragraph for a fiscal year shall be avail-
21 able until expended.
22 ‘‘(h) TREATMENT OF TRHCA MEDICARE MEDICAL
23 HOME DEMONSTRATION FUNDING.—
24 ‘‘(1) In addition to funds otherwise available for
25 payment of medical home services under subsection

1 (c)(3), there shall also be available the amount pro-
2 vided in subsection (g) of section 204 of division B
3 of the Tax Relief and Health Care Act of 2006 (42
4 U.S.C. 1395b–1 note).
5 "(2) Notwithstanding section 1302(c) of the
6 America's Affordable Health Choices Act of 2009, in
7 addition to funds provided in paragraph (1) and
8 subsection (g)(2)(A), the funding for medical home
9 services that would otherwise have been available if
10 such section 204 medical home demonstration had
11 been implemented (without regard to subsection (g)
12 of such section) shall be available to the independent
13 patient-centered medical home model described in
14 subsection (c).".
15 (b) EFFECTIVE DATE.—The amendment made by
16 this section shall apply to services furnished on or after
17 the date of the enactment of this Act.
18 (c) CONFORMING REPEAL.—Section 204 of division
19 B of the Tax Relief and Health Care Act of 2006 (42
20 U.S.C. 1395b–1 note), as amended by section 133(a)(2)
21 of the Medicare Improvements for Patients and Providers
22 Act of 2008 (Public Law 110–275), is repealed.

1 **SEC. 1303. PAYMENT INCENTIVE FOR SELECTED PRIMARY**
2 **CARE SERVICES.**

3 (a) IN GENERAL.—Section 1833 of the Social Secu-
4 rity Act is amended by inserting after subsection (o) the
5 following new subsection:

6 "(p) PRIMARY CARE PAYMENT INCENTIVES.—

7 "(1) IN GENERAL.—In the case of primary care
8 services (as defined in paragraph (2)) furnished on
9 or after January 1, 2011, by a primary care practi-
10 tioner (as defined in paragraph (3)) for which
11 amounts are payable under section 1848, in addition
12 to the amount otherwise paid under this part there
13 shall also be paid to the practitioner (or to an em-
14 ployer or facility in the cases described in clause (A)
15 of section 1842(b)(6)) (on a monthly or quarterly
16 basis) from the Federal Supplementary Medical In-
17 surance Trust Fund an amount equal 5 percent (or
18 10 percent if the practitioner predominately fur-
19 nishes such services in an area that is designated
20 (under section 332(a)(1)(A) of the Public Health
21 Service Act) as a primary care health professional
22 shortage area.

23 "(2) PRIMARY CARE SERVICES DEFINED.—In
24 this subsection, the term 'primary care services'—

1 "(A) means services which are evaluation
2 and management services as defined in section
3 1848(j)(5)(A); and
4 "(B) includes services furnished by another
5 health care professional that would be described
6 in subparagraph (A) if furnished by a physi-
7 cian.
8 "(3) PRIMARY CARE PRACTITIONER DE-
9 FINED.—In this subsection, the term 'primary care
10 practitioner'—
11 "(A) means a physician or other health
12 care practitioner (including a nurse practi-
13 tioner) who—
14 "(i) specializes in family medicine,
15 general internal medicine, general pediat-
16 rics, geriatrics, or obstetrics and gyne-
17 cology; and
18 "(ii) has allowed charges for primary
19 care services that account for at least 50
20 percent of the physician's or practitioner's
21 total allowed charges under section 1848,
22 as determined by the Secretary for the
23 most recent period for which data are
24 available; and

1 "(B) includes a physician assistant who is
2 under the supervision of a physician described
3 in subparagraph (A).
4 "(4) LIMITATION ON REVIEW.—There shall be
5 no administrative or judicial review under section
6 1869, section 1878, or otherwise, respecting—
7 "(A) any determination or designation
8 under this subsection;
9 "(B) the identification of services as pri-
10 mary care services under this subsection; and
11 "(C) the identification of a practitioner as
12 a primary care practitioner under this sub-
13 section.
14 "(5) COORDINATION WITH OTHER PAY-
15 MENTS.—
16 "(A) WITH OTHER PRIMARY CARE INCEN-
17 TIVES.—The provisions of this subsection shall
18 not be taken into account in applying sub-
19 sections (m) and (u) and any payment under
20 such subsections shall not be taken into account
21 in computing payments under this subsection.
22 "(B) WITH QUALITY INCENTIVES.—Pay-
23 ments under this subsection shall not be taken
24 into account in determining the amounts that

1 would otherwise be paid under this part for
2 purposes of section 1834(g)(2)(B).''.
3 (b) CONFORMING AMENDMENTS.—
4 (1) Section 1833 of such Act (42 U.S.C.
5 1395l(m)) is amended by redesignating paragraph
6 (4) as paragraph (5) and by inserting after para-
7 graph (3) the following new paragraph:
8 ''(4) The provisions of this subsection shall not be
9 taken into account in applying subsections (m) or (u) and
10 any payment under such subsections shall not be taken
11 into account in computing payments under this sub-
12 section.''.
13 (2) Section 1848(m)(5)(B) of such Act (42
14 U.S.C. 1395w–4(m)(5)(B)) is amended by inserting
15 '', (p),'' after ''(m)''.
16 (3) Section 1848(o)(1)(B)(iv) of such Act (42
17 U.S.C. 1395w–4(o)(1)(B)(iv)) is amended by insert-
18 ing ''primary care'' before ''health professional
19 shortage area''.
20 **SEC. 1304. INCREASED REIMBURSEMENT RATE FOR CER-**
21 **TIFIED NURSE-MIDWIVES.**
22 (a) IN GENERAL.—Section 1833(a)(1)(K) of the So-
23 cial Security Act (42 U.S.C.1395l(a)(1)(K)) is amended
24 by striking ''(but in no event'' and all that follows through
25 ''performed by a physician)''.

1 (b) EFFECTIVE DATE.—The amendment made by
2 subsection (a) shall apply to services furnished on or after
3 January 1, 2011.

4 **SEC. 1305. COVERAGE AND WAIVER OF COST-SHARING FOR**
5 **PREVENTIVE SERVICES.**

6 (a) MEDICARE COVERED PREVENTIVE SERVICES DE-
7 FINED.—Section 1861 of the Social Security Act (42
8 U.S.C. 1395x), as amended by section 1233(a)(1)(B), is
9 amended by adding at the end the following new sub-
10 section:

11 ''Medicare Covered Preventive Services

12 ''(iii)(1) Subject to the succeeding provisions of this
13 subsection, the term 'Medicare covered preventive services'
14 means the following:

15 ''(A) Prostate cancer screening tests (as defined
16 in subsection (oo)).

17 ''(B) Colorectal cancer screening tests (as de-
18 fined in subsection (pp).

19 ''(C) Diabetes outpatient self-management
20 training services (as defined in subsection (qq)).

21 ''(D) Screening for glaucoma for certain indi-
22 viduals (as described in subsection (s)(2)(U)).

23 ''(E) Medical nutrition therapy services for cer-
24 tain individuals (as described in subsection
25 (s)(2)(V)).

1 "(F) An initial preventive physical examination
2 (as defined in subsection (ww)).
3 "(G) Cardiovascular screening blood tests (as
4 defined in subsection (xx)(1)).
5 "(H) Diabetes screening tests (as defined in
6 subsection (yy)).
7 "(I) Ultrasound screening for abdominal aortic
8 aneurysm for certain individuals (as described in
9 subsection (s)(2)(AA)).
10 "(J) Pneumococcal and influenza vaccines and
11 their administration (as described in subsection
12 (s)(10)(A)) and hepatitis B vaccine and its adminis-
13 tration for certain individuals (as described in sub-
14 section (s)(10)(B)).
15 "(K) Screening mammography (as defined in
16 subsection (jj)).
17 "(L) Screening pap smear and screening pelvic
18 exam (as defined in subsection (nn)).
19 "(M) Bone mass measurement (as defined in
20 subsection (rr)).
21 "(N) Kidney disease education services (as de-
22 fined in subsection (ggg)).
23 "(O) Additional preventive services (as defined
24 in subsection (ddd)).

1 "(2) With respect to specific Medicare covered pre-
2 ventive services, the limitations and conditions described
3 in the provisions referenced in paragraph (1) with respect
4 to such services shall apply.".
5 (b) PAYMENT AND ELIMINATION OF COST-SHAR-
6 ING.—
7 (1) IN GENERAL.—
8 (A) IN GENERAL.—Section 1833(a) of the
9 Social Security Act (42 U.S.C. 1395l(a)) is
10 amended by adding after and below paragraph
11 (9) the following:
12 "With respect to Medicare covered preventive services, in
13 any case in which the payment rate otherwise provided
14 under this part is computed as a percent of less than 100
15 percent of an actual charge, fee schedule rate, or other
16 rate, such percentage shall be increased to 100 percent.".
17 (B) APPLICATION TO SIGMOIDOSCOPIES
18 AND COLONOSCOPIES.—Section 1834(d) of such
19 Act (42 U.S.C. 1395m(d)) is amended—
20 (i) in paragraph (2)(C), by amending
21 clause (ii) to read as follows:
22 "(ii) NO COINSURANCE.—In the case
23 of a beneficiary who receives services de-
24 scribed in clause (i), there shall be no coin-
25 surance applied."; and

1 (ii) in paragraph (3)(C), by amending
2 clause (ii) to read as follows:
3 "(ii) NO COINSURANCE.—In the case
4 of a beneficiary who receives services de-
5 scribed in clause (i), there shall be no coin-
6 surance applied.".
7 (2) ELIMINATION OF COINSURANCE IN OUT-
8 PATIENT HOSPITAL SETTINGS.—
9 (A) EXCLUSION FROM OPD FEE SCHED-
10 ULE.—Section 1833(t)(1)(B)(iv) of the Social
11 Security Act (42 U.S.C. 1395l(t)(1)(B)(iv)) is
12 amended by striking "screening mammography
13 (as defined in section 1861(jj)) and diagnostic
14 mammography" and inserting "diagnostic
15 mammograms and Medicare covered preventive
16 services (as defined in section 1861(iii)(1))".
17 (B) CONFORMING AMENDMENTS.—Section
18 1833(a)(2) of the Social Security Act (42
19 U.S.C. 1395l(a)(2)) is amended—
20 (i) in subparagraph (F), by striking
21 "and" after the semicolon at the end;
22 (ii) in subparagraph (G)(ii), by adding
23 "and" at the end; and
24 (iii) by adding at the end the fol-
25 lowing new subparagraph:

1 "(H) with respect to additional preventive
2 services (as defined in section 1861(ddd)) fur-
3 nished by an outpatient department of a hos-
4 pital, the amount determined under paragraph
5 (1)(W);".

6 (3) WAIVER OF APPLICATION OF DEDUCTIBLE
7 FOR ALL PREVENTIVE SERVICES.—The first sen-
8 tence of section 1833(b) of the Social Security Act
9 (42 U.S.C. 1395l(b)) is amended—

10 (A) in clause (1), by striking "items and
11 services described in section 1861(s)(10)(A)"
12 and inserting "Medicare covered preventive
13 services (as defined in section 1861(iii))";

14 (B) by inserting "and" before "(4)"; and

15 (C) by striking clauses (5) through (8).

16 (4) APPLICATION TO PROVIDERS OF SERV-
17 ICES.—Section 1866(a)(2)(A)(ii) of such Act (42
18 U.S.C. 1395cc(a)(2)(A)(ii)) is amended by inserting
19 "other than for Medicare covered preventive services
20 and" after "for such items and services (".

21 (c) EFFECTIVE DATE.—The amendments made by
22 this section shall apply to services furnished on or after
23 January 1, 2011.

1 **SEC. 1306. WAIVER OF DEDUCTIBLE FOR COLORECTAL**
2 **CANCER SCREENING TESTS REGARDLESS OF**
3 **CODING, SUBSEQUENT DIAGNOSIS, OR ANCIL-**
4 **LARY TISSUE REMOVAL.**

5 (a) IN GENERAL.—Section 1833 of the Social Secu-
6 rity Act (42 U.S.C. 1395l(b)), as amended by section
7 1305(b), is further amended—

8 (1) in subsection (a), in the sentence added by
9 section 1305(b)(1)(A), by inserting ‘‘(including serv-
10 ices described in the last sentence of section
11 1833(b))’’ after ‘‘preventive services’’; and

12 (2) in subsection (b), by adding at the end the
13 following new sentence: ‘‘Clause (1) of the first sen-
14 tence of this subsection shall apply with respect to
15 a colorectal cancer screening test regardless of the
16 code that is billed for the establishment of a diag-
17 nosis as a result of the test, or for the removal of
18 tissue or other matter or other procedure that is fur-
19 nished in connection with, as a result of, and in the
20 same clinical encounter as, the screening test.’’.

21 (b) EFFECTIVE DATE.—The amendment made by
22 subsection (a) shall apply to items and services furnished
23 on or after January 1, 2011.

1 **SEC. 1307. EXCLUDING CLINICAL SOCIAL WORKER SERV-**
2 **ICES FROM COVERAGE UNDER THE MEDI-**
3 **CARE SKILLED NURSING FACILITY PROSPEC-**
4 **TIVE PAYMENT SYSTEM AND CONSOLIDATED**
5 **PAYMENT.**

6 (a) IN GENERAL.—Section 1888(e)(2)(A)(ii) of the
7 Social Security Act (42 U.S.C. 1395yy(e)(2)(A)(ii)) is
8 amended by inserting ''clinical social worker services,''
9 after ''qualified psychologist services,''.

10 (b) CONFORMING AMENDMENT.—Section
11 1861(hh)(2) of the Social Security Act (42 U.S.C.
12 1395x(hh)(2)) is amended by striking ''and other than
13 services furnished to an inpatient of a skilled nursing facil-
14 ity which the facility is required to provide as a require-
15 ment for participation''.

16 (c) EFFECTIVE DATE.—The amendments made by
17 this section shall apply to items and services furnished on
18 or after July 1, 2010.

19 **SEC. 1308. COVERAGE OF MARRIAGE AND FAMILY THERA-**
20 **PIST SERVICES AND MENTAL HEALTH COUN-**
21 **SELOR SERVICES.**

22 (a) COVERAGE OF MARRIAGE AND FAMILY THERA-
23 PIST SERVICES.—
24 (1) COVERAGE OF SERVICES.—Section
25 1861(s)(2) of the Social Security Act (42 U.S.C.

1 1395x(s)(2)), as amended by section 1235, is
2 amended—
3 (A) in subparagraph (EE), by striking
4 ''and'' at the end;
5 (B) in subparagraph (FF), by adding
6 ''and'' at the end; and
7 (C) by adding at the end the following new
8 subparagraph:
9 ''(GG) marriage and family therapist serv-
10 ices (as defined in subsection (jjj));''.
11 (2) DEFINITION.—Section 1861 of the Social
12 Security Act (42 U.S.C. 1395x), as amended by sec-
13 tions 1235 and 1305, is amended by adding at the
14 end the following new subsection:
15 ''Marriage and Family Therapist Services
16 ''(jjj)(1) The term 'marriage and family therapist
17 services' means services performed by a marriage and
18 family therapist (as defined in paragraph (2)) for the diag-
19 nosis and treatment of mental illnesses, which the mar-
20 riage and family therapist is legally authorized to perform
21 under State law (or the State regulatory mechanism pro-
22 vided by State law) of the State in which such services
23 are performed, as would otherwise be covered if furnished
24 by a physician or as incident to a physician's professional
25 service, but only if no facility or other provider charges

1 or is paid any amounts with respect to the furnishing of
2 such services.
3 ''(2) The term 'marriage and family therapist' means
4 an individual who—
5 ''(A) possesses a master's or doctoral degree
6 which qualifies for licensure or certification as a
7 marriage and family therapist pursuant to State
8 law;
9 ''(B) after obtaining such degree has performed
10 at least 2 years of clinical supervised experience in
11 marriage and family therapy; and
12 ''(C) is licensed or certified as a marriage and
13 family therapist in the State in which marriage and
14 family therapist services are performed.''.
15 (3) PROVISION FOR PAYMENT UNDER PART
16 B.—Section 1832(a)(2)(B) of the Social Security
17 Act (42 U.S.C. 1395k(a)(2)(B)) is amended by add-
18 ing at the end the following new clause:
19 ''(v) marriage and family therapist
20 services;''.
21 (4) AMOUNT OF PAYMENT.—
22 (A) IN GENERAL.—Section 1833(a)(1) of
23 the Social Security Act (42 U.S.C. 1395l(a)(1))
24 is amended—

1 (i) by striking "and" before "(W)";
2 and
3 (ii) by inserting before the semicolon
4 at the end the following: ", and (X) with
5 respect to marriage and family therapist
6 services under section 1861(s)(2)(GG), the
7 amounts paid shall be 80 percent of the
8 lesser of the actual charge for the services
9 or 75 percent of the amount determined
10 for payment of a psychologist under clause
11 (L)".
12 (B) DEVELOPMENT OF CRITERIA WITH RE-
13 SPECT TO CONSULTATION WITH A HEALTH
14 CARE PROFESSIONAL.—The Secretary of Health
15 and Human Services shall, taking into consider-
16 ation concerns for patient confidentiality, de-
17 velop criteria with respect to payment for mar-
18 riage and family therapist services for which
19 payment may be made directly to the marriage
20 and family therapist under part B of title
21 XVIII of the Social Security Act (42 U.S.C.
22 1395j et seq.) under which such a therapist
23 must agree to consult with a patient's attending
24 or primary care physician or nurse practitioner
25 in accordance with such criteria.

1 (5) EXCLUSION OF MARRIAGE AND FAMILY
2 THERAPIST SERVICES FROM SKILLED NURSING FA-
3 CILITY PROSPECTIVE PAYMENT SYSTEM.—Section
4 1888(e)(2)(A)(ii) of the Social Security Act (42
5 U.S.C. 1395yy(e)(2)(A)(ii)), as amended by section
6 1307(a), is amended by inserting ''marriage and
7 family therapist services (as defined in subsection
8 (jjj)(1)),'' after ''clinical social worker services,''.
9 (6) COVERAGE OF MARRIAGE AND FAMILY
10 THERAPIST SERVICES PROVIDED IN RURAL HEALTH
11 CLINICS AND FEDERALLY QUALIFIED HEALTH CEN-
12 TERS.—Section 1861(aa)(1)(B) of the Social Secu-
13 rity Act (42 U.S.C. 1395x(aa)(1)(B)) is amended by
14 striking ''or by a clinical social worker (as defined
15 in subsection (hh)(1)),'' and inserting '', by a clinical
16 social worker (as defined in subsection (hh)(1)), or
17 by a marriage and family therapist (as defined in
18 subsection (jjj)(2)),''.
19 (7) INCLUSION OF MARRIAGE AND FAMILY
20 THERAPISTS AS PRACTITIONERS FOR ASSIGNMENT
21 OF CLAIMS.—Section 1842(b)(18)(C) of the Social
22 Security Act (42 U.S.C. 1395u(b)(18)(C)) is amend-
23 ed by adding at the end the following new clause:
24 ''(vii) A marriage and family therapist (as de-
25 fined in section 1861(jjj)(2)).''.

1 (b) COVERAGE OF MENTAL HEALTH COUNSELOR
2 SERVICES.—
3 (1) COVERAGE OF SERVICES.—Section
4 1861(s)(2) of the Social Security Act (42 U.S.C.
5 1395x(s)(2)), as previously amended, is further
6 amended—
7 (A) in subparagraph (FF), by striking
8 "and" at the end;
9 (B) in subparagraph (GG), by inserting
10 "and" at the end; and
11 (C) by adding at the end the following new
12 subparagraph:
13 "(HH) mental health counselor services (as de-
14 fined in subsection (kkk)(1));".
15 (2) DEFINITION.—Section 1861 of the Social
16 Security Act (42 U.S.C. 1395x), as previously
17 amended, is amended by adding at the end the fol-
18 lowing new subsection:
19 "Mental Health Counselor Services
20 "(kkk)(1) The term 'mental health counselor services'
21 means services performed by a mental health counselor (as
22 defined in paragraph (2)) for the diagnosis and treatment
23 of mental illnesses which the mental health counselor is
24 legally authorized to perform under State law (or the
25 State regulatory mechanism provided by the State law) of

1 the State in which such services are performed, as would
2 otherwise be covered if furnished by a physician or as inci-
3 dent to a physician's professional service, but only if no
4 facility or other provider charges or is paid any amounts
5 with respect to the furnishing of such services.

6 "(2) The term 'mental health counselor' means an
7 individual who—

8 "(A) possesses a master's or doctor's degree
9 which qualifies the individual for licensure or certifi-
10 cation for the practice of mental health counseling in
11 the State in which the services are performed;

12 "(B) after obtaining such a degree has per-
13 formed at least 2 years of supervised mental health
14 counselor practice; and

15 "(C) is licensed or certified as a mental health
16 counselor or professional counselor by the State in
17 which the services are performed.".

18 (3) PROVISION FOR PAYMENT UNDER PART
19 B.—Section 1832(a)(2)(B) of the Social Security
20 Act (42 U.S.C. 1395k(a)(2)(B)), as amended by
21 subsection (a)(3), is further amended—

22 (A) by striking "and" at the end of clause
23 (iv);

24 (B) by adding "and" at the end of clause
25 (v); and

1 (C) by adding at the end the following new
2 clause:
3 "(vi) mental health counselor serv-
4 ices;".
5 (4) AMOUNT OF PAYMENT.—
6 (A) IN GENERAL.—Section 1833(a)(1) of
7 the Social Security Act (42 U.S.C.
8 1395l(a)(1)), as amended by subsection (a), is
9 further amended—
10 (i) by striking "and"before "(X)";
11 and
12 (ii) by inserting before the semicolon
13 at the end the following: ", and (Y), with
14 respect to mental health counselor services
15 under section 1861(s)(2)(HH), the
16 amounts paid shall be 80 percent of the
17 lesser of the actual charge for the services
18 or 75 percent of the amount determined
19 for payment of a psychologist under clause
20 (L)".
21 (B) DEVELOPMENT OF CRITERIA WITH RE-
22 SPECT TO CONSULTATION WITH A PHYSICIAN.—
23 The Secretary of Health and Human Services
24 shall, taking into consideration concerns for pa-
25 tient confidentiality, develop criteria with re-

1 spect to payment for mental health counselor
2 services for which payment may be made di-
3 rectly to the mental health counselor under part
4 B of title XVIII of the Social Security Act (42
5 U.S.C. 1395j et seq.) under which such a coun-
6 selor must agree to consult with a patient's at-
7 tending or primary care physician in accordance
8 with such criteria.

9 (5) EXCLUSION OF MENTAL HEALTH COUN-
10 SELOR SERVICES FROM SKILLED NURSING FACILITY
11 PROSPECTIVE PAYMENT SYSTEM.—Section
12 1888(e)(2)(A)(ii) of the Social Security Act (42
13 U.S.C. 1395yy(e)(2)(A)(ii)), as amended by section
14 1307(a) and subsection (a), is amended by inserting
15 ''mental health counselor services (as defined in sec-
16 tion 1861(kkk)(1)),'' after ''marriage and family
17 therapist services (as defined in subsection
18 (jjj)(1)),''.

19 (6) COVERAGE OF MENTAL HEALTH COUN-
20 SELOR SERVICES PROVIDED IN RURAL HEALTH
21 CLINICS AND FEDERALLY QUALIFIED HEALTH CEN-
22 TERS.—Section 1861(aa)(1)(B) of the Social Secu-
23 rity Act (42 U.S.C. 1395x(aa)(1)(B)), as amended
24 by subsection (a), is amended by striking ''or by a
25 marriage and family therapist (as defined in sub-

1 section (jjj)(2)),'' and inserting ''by a marriage and
2 family therapist (as defined in subsection (jjj)(2)),
3 or a mental health counselor (as defined in sub-
4 section (kkk)(2)),''.
5 (7) INCLUSION OF MENTAL HEALTH COUN-
6 SELORS AS PRACTITIONERS FOR ASSIGNMENT OF
7 CLAIMS.—Section 1842(b)(18)(C) of the Social Se-
8 curity Act (42 U.S.C. 1395u(b)(18)(C)), as amended
9 by subsection (a)(7), is amended by adding at the
10 end the following new clause:
11 ''(viii) A mental health counselor (as defined in
12 section 1861(kkk)(2)).''.
13 (c) EFFECTIVE DATE.—The amendments made by
14 this section shall apply to items and services furnished on
15 or after January 1, 2011.

16 **SEC. 1309. EXTENSION OF PHYSICIAN FEE SCHEDULE MEN-**
17 **TAL HEALTH ADD-ON.**

18 Section 138(a)(1) of the Medicare Improvements for
19 Patients and Providers Act of 2008 (Public Law 110–275)
20 is amended by striking ''December 31, 2009'' and insert-
21 ing ''December 31, 2011''.

22 **SEC. 1310. EXPANDING ACCESS TO VACCINES.**

23 (a) IN GENERAL.—Paragraph (10) of section
24 1861(s) of the Social Security Act (42 U.S.C. 1395w(s))
25 is amended to read as follows:

1 "(10) federally recommended vaccines (as de-
2 fined in subsection (lll)) and their respective admin-
3 istration;".
4 (b) FEDERALLY RECOMMENDED VACCINES DE-
5 FINED.—Section 1861 of such Act is further amended by
6 adding at the end the following new subsection:
7 "Federally Recommended Vaccines
8 "(lll) The term 'federally recommended vaccine'
9 means an approved vaccine recommended by the Advisory
10 Committee on Immunization Practices (an advisory com-
11 mittee established by the Secretary, acting through the Di-
12 rector of the Centers for Disease Control and Preven-
13 tion).".
14 (c) CONFORMING AMENDMENTS.—
15 (1) Section 1833 of such Act (42 U.S.C. 1395l)
16 is amended, in each of subsections (a)(1)(B),
17 (a)(2)(G), (a)(3)(A), and (b)(1) (as amended by sec-
18 tion 1305(b)), by striking "1861(s)(10)(A)" or
19 "1861(s)(10)(B)" and inserting "1861(s)(10)" each
20 place it appears.
21 (2) Section 1842(o)(1)(A)(iv) of such Act (42
22 U.S.C. 1395u(o)(1)(A)(iv)) is amended—
23 (A) by striking "subparagraph (A) or (B)
24 of"; and

1 (B) by inserting before the period the fol-
2 lowing: ‘‘and before January 1, 2011, and influ-
3 enza vaccines furnished on or after January 1,
4 2011’’.
5 (3) Section 1847A(c)(6) of such Act (42 U.S.C.
6 1395w–3a(c)(6)) is amended by striking subpara-
7 graph (G) and inserting the following:
8 ‘‘(G) IMPLEMENTATION.—Chapter 35 of
9 title 44, United States Code shall not apply to
10 manufacturer provision of information pursuant
11 to section 1927(b)(3)(A)(iii) for purposes of im-
12 plementation of this section.’’.
13 (4) Section 1860D–2(e)(1)(B) of such Act (42
14 U.S.C. 1395w–102(e)(1)(B)) is amended by striking
15 ‘‘such term includes a vaccine’’ and all that follows
16 through ‘‘its administration) and’’.
17 (5) Section 1861(ww)(2)(A) of such Act (42
18 U.S.C. 1395x(ww)(2)(A))) is amended by striking
19 ‘‘Pneumococcal, influenza, and hepatitis B and ad-
20 ministration’’ and inserting ‘‘Federally recommended
21 vaccines (as defined in subsection (lll)) and their re-
22 spective administration’’.
23 (6) Section 1861(iii)(1) of such Act, as added
24 by section 1305(a), is amended by amending sub-
25 paragraph (J) to read as follows:

1 "(J) Federally recommended vaccines (as de-
2 fined in subsection (lll)) and their respective admin-
3 istration.".
4 (7) Section 1927(b)(3)(A)(iii) of such Act (42
5 U.S.C. 1396r–8(b)(3)(A)(iii)) is amended, in the
6 matter following subclause (III), by inserting
7 "(A)(iv) (including influenza vaccines furnished on
8 or after January 1, 2011)," after "described in sub-
9 paragraph."
10 (d) EFFECTIVE DATES.—The amendments made
11 by—
12 (1) this section (other than by subsection
13 (c)(7)) shall apply to vaccines administered on or
14 after January 1, 2011; and
15 (2) by subsection (c)(7) shall apply to calendar
16 quarters beginning on or after January 1, 2010.
17 **SEC. 1311. EXPANSION OF MEDICARE-COVERED PREVEN-**
18 **TIVE SERVICES AT FEDERALLY QUALIFIED**
19 **HEALTH CENTERS.**
20 Section 1861(aa)(3)(A) of the Social Security Act (42
21 U.S.C. 1395w (aa)(3)(A)) is amended to read as follows:
22 "(A) services of the type described sub-
23 paragraphs (A) through (C) of paragraph (1)
24 and services described in Section 1861(iii);
25 and".

1 # TITLE IV—QUALITY
2 ## Subtitle A—Comparative
3 ## Effectiveness Research
4 **SEC. 1401. COMPARATIVE EFFECTIVENESS RESEARCH.**
5 (a) IN GENERAL.—title XI of the Social Security Act
6 is amended by adding at the end the following new part:
7 "PART D—COMPARATIVE EFFECTIVENESS RESEARCH
8 "COMPARATIVE EFFECTIVENESS RESEARCH
9 "SEC. 1181. (a) CENTER FOR COMPARATIVE EFFEC-
10 TIVENESS RESEARCH ESTABLISHED.—
11 "(1) IN GENERAL.—The Secretary shall estab-
12 lish within the Agency for Healthcare Research and
13 Quality a Center for Comparative Effectiveness Re-
14 search (in this section referred to as the 'Center') to
15 conduct, support, and synthesize research (including
16 research conducted or supported under section 1013
17 of the Medicare Prescription Drug, Improvement,
18 and Modernization Act of 2003) with respect to the
19 outcomes, effectiveness, and appropriateness of
20 health care services and procedures in order to iden-
21 tify the manner in which diseases, disorders, and
22 other health conditions can most effectively and ap-
23 propriately be prevented, diagnosed, treated, and
24 managed clinically.
25 "(2) DUTIES.—The Center shall—

1 "(A) conduct, support, and synthesize re-
2 search relevant to the comparative effectiveness
3 of the full spectrum of health care items, serv-
4 ices and systems, including pharmaceuticals,
5 medical devices, medical and surgical proce-
6 dures, and other medical interventions;
7 "(B) conduct and support systematic re-
8 views of clinical research, including original re-
9 search conducted subsequent to the date of the
10 enactment of this section;
11 "(C) continuously develop rigorous sci-
12 entific methodologies for conducting compara-
13 tive effectiveness studies, and use such meth-
14 odologies appropriately;
15 "(D) submit to the Comparative Effective-
16 ness Research Commission, the Secretary, and
17 Congress appropriate relevant reports described
18 in subsection (d)(2); and
19 "(E) encourage, as appropriate, the devel-
20 opment and use of clinical registries and the de-
21 velopment of clinical effectiveness research data
22 networks from electronic health records, post
23 marketing drug and medical device surveillance
24 efforts, and other forms of electronic health
25 data.

1 "(3) POWERS.—
2 "(A) OBTAINING OFFICIAL DATA.—The
3 Center may secure directly from any depart-
4 ment or agency of the United States informa-
5 tion necessary to enable it to carry out this sec-
6 tion. Upon request of the Center, the head of
7 that department or agency shall furnish that in-
8 formation to the Center on an agreed upon
9 schedule.
10 "(B) DATA COLLECTION.—In order to
11 carry out its functions, the Center shall—
12 "(i) utilize existing information, both
13 published and unpublished, where possible,
14 collected and assessed either by its own
15 staff or under other arrangements made in
16 accordance with this section,
17 "(ii) carry out, or award grants or
18 contracts for, original research and experi-
19 mentation, where existing information is
20 inadequate, and
21 "(iii) adopt procedures allowing any
22 interested party to submit information for
23 the use by the Center and Commission
24 under subsection (b) in making reports
25 and recommendations.

1 "(C) ACCESS OF GAO TO INFORMATION.—
2 The Comptroller General shall have unrestricted
3 access to all deliberations, records, and non-
4 proprietary data of the Center and Commission
5 under subsection (b), immediately upon request.
6 "(D) PERIODIC AUDIT.—The Center and
7 Commission under subsection (b) shall be sub-
8 ject to periodic audit by the Comptroller Gen-
9 eral.
10 "(b) OVERSIGHT BY COMPARATIVE EFFECTIVENESS
11 RESEARCH COMMISSION.—
12 "(1) IN GENERAL.—The Secretary shall estab-
13 lish an independent Comparative Effectiveness Re-
14 search Commission (in this section referred to as the
15 'Commission') to oversee and evaluate the activities
16 carried out by the Center under subsection (a), sub-
17 ject to the authority of the Secretary, to ensure such
18 activities result in highly credible research and infor-
19 mation resulting from such research.
20 "(2) DUTIES.—The Commission shall—
21 "(A) determine national priorities for re-
22 search described in subsection (a) and in mak-
23 ing such determinations consult with a broad
24 array of public and private stakeholders, includ-

1 ing patients and health care providers and pay-
2 ers;
3 ‘‘(B) monitor the appropriateness of use of
4 the CERTF described in subsection (g) with re-
5 spect to the timely production of comparative
6 effectiveness research determined to be a na-
7 tional priority under subparagraph (A);
8 ‘‘(C) identify highly credible research
9 methods and standards of evidence for such re-
10 search to be considered by the Center;
11 ‘‘(D) review the methodologies developed
12 by the center under subsection (a)(2)(C);
13 ‘‘(E) not later than one year after the date
14 of the enactment of this section, enter into an
15 arrangement under which the Institute of Medi-
16 cine of the National Academy of Sciences shall
17 conduct an evaluation and report on standards
18 of evidence for such research;
19 ‘‘(F) support forums to increase stake-
20 holder awareness and permit stakeholder feed-
21 back on the efforts of the Center to advance
22 methods and standards that promote highly
23 credible research;
24 ‘‘(G) make recommendations for policies
25 that would allow for public access of data pro-

1 duced under this section, in accordance with ap-
2 propriate privacy and proprietary practices,
3 while ensuring that the information produced
4 through such data is timely and credible;

5 "(H) appoint a clinical perspective advisory
6 panel for each research priority determined
7 under subparagraph (A), which shall consult
8 with patients and advise the Center on research
9 questions, methods, and evidence gaps in terms
10 of clinical outcomes for the specific research in-
11 quiry to be examined with respect to such pri-
12 ority to ensure that the information produced
13 from such research is clinically relevant to deci-
14 sions made by clinicians and patients at the
15 point of care;

16 "(I) make recommendations for the pri-
17 ority for periodic reviews of previous compara-
18 tive effectiveness research and studies con-
19 ducted by the Center under subsection (a);

20 "(J) routinely review processes of the Cen-
21 ter with respect to such research to confirm
22 that the information produced by such research
23 is objective, credible, consistent with standards
24 of evidence established under this section, and
25 developed through a transparent process that

1 includes consultations with appropriate stake-
2 holders; and
3 "(K) make recommendations to the center
4 for the broad dissemination of the findings of
5 research conducted and supported under this
6 section that enables clinicians, patients, con-
7 sumers, and payers to make more informed
8 health care decisions that improve quality and
9 value.
10 "(3) COMPOSITION OF COMMISSION.—
11 "(A) IN GENERAL.—The members of the
12 Commission shall consist of—
13 "(i) the Director of the Agency for
14 Healthcare Research and Quality;
15 "(ii) the Chief Medical Officer of the
16 Centers for Medicare & Medicaid Services;
17 and
18 "(iii) 15 additional members who shall
19 represent broad constituencies of stake-
20 holders including clinicians, patients, re-
21 searchers, third-party payers, consumers of
22 Federal and State beneficiary programs.
23 Of such members, at least 9 shall be practicing
24 physicians, health care practitioners, con-
25 sumers, or patients.

1 "(B) QUALIFICATIONS.—
2 "(i) DIVERSE REPRESENTATION OF
3 PERSPECTIVES.—The members of the
4 Commission shall represent a broad range
5 of perspectives and shall collectively have
6 experience in the following areas:
7 "(I) Epidemiology.
8 "(II) Health services research.
9 "(III) Bioethics.
10 "(IV) Decision sciences.
11 "(V) Health disparities.
12 "(VI) Economics.
13 "(ii) DIVERSE REPRESENTATION OF
14 HEALTH CARE COMMUNITY.—At least one
15 member shall represent each of the fol-
16 lowing health care communities:
17 "(I) Patients.
18 "(II) Health care consumers.
19 "(III) Practicing Physicians, in-
20 cluding surgeons.
21 "(IV) Other health care practi-
22 tioners engaged in clinical care.
23 "(V) Employers.
24 "(VI) Public payers.
25 "(VII) Insurance plans.

1 "(VIII) Clinical researchers who
2 conduct research on behalf of pharma-
3 ceutical or device manufacturers.
4 "(C) LIMITATION.—No more than 3 of the
5 Members of the Commission may be representa-
6 tives of pharmaceutical or device manufacturers
7 and such representatives shall be clinical re-
8 searchers described under subparagraph
9 (B)(ii)(VIII).
10 "(4) APPOINTMENT.—
11 "(A) IN GENERAL.—The Secretary shall
12 appoint the members of the Commission.
13 "(B) CONSULTATION.—In considering can-
14 didates for appointment to the Commission, the
15 Secretary may consult with the Government Ac-
16 countability Office and the Institute of Medicine
17 of the National Academy of Sciences.
18 "(5) CHAIRMAN; VICE CHAIRMAN.—The Sec-
19 retary shall designate a member of the Commission,
20 at the time of appointment of the member, as Chair-
21 man and a member as Vice Chairman for that term
22 of appointment, except that in the case of vacancy
23 of the Chairmanship or Vice Chairmanship, the Sec-
24 retary may designate another member for the re-
25 mainder of that member's term. The Chairman shall

1 serve as an ex officio member of the National Advi-
2 sory Council of the Agency for Health Care Re-
3 search and Quality under section 931(c)(3)(B) of
4 the Public Health Service Act.
5 ''(6) TERMS.—
6 ''(A) IN GENERAL.—Except as provided in
7 subparagraph (B), each member of the Com-
8 mission shall be appointed for a term of 4
9 years.
10 ''(B) TERMS OF INITIAL APPOINTEES.—Of
11 the members first appointed—
12 ''(i) 8 shall be appointed for a term of
13 4 years; and
14 ''(ii) 7 shall be appointed for a term
15 of 3 years.
16 ''(7) COORDINATION.—To enhance effectiveness
17 and coordination, the Secretary is encouraged, to the
18 greatest extent possible, to seek coordination be-
19 tween the Commission and the National Advisory
20 Council of the Agency for Healthcare Research and
21 Quality.
22 ''(8) CONFLICTS OF INTEREST.—
23 ''(A) IN GENERAL.—In appointing the
24 members of the Commission or a clinical per-
25 spective advisory panel described in paragraph

1 (2)(H), the Secretary or the Commission, re-
2 spectively, shall take into consideration any fi-
3 nancial interest (as defined in subparagraph
4 (D)), consistent with this paragraph, and de-
5 velop a plan for managing any identified con-
6 flicts.

7 "(B) EVALUATION AND CRITERIA.—When
8 considering an appointment to the Commission
9 or a clinical perspective advisory panel de-
10 scribed paragraph (2)(H) the Secretary or the
11 Commission shall review the expertise of the in-
12 dividual and the financial disclosure report filed
13 by the individual pursuant to the Ethics in Gov-
14 ernment Act of 1978 for each individual under
15 consideration for the appointment, so as to re-
16 duce the likelihood that an appointed individual
17 will later require a written determination as re-
18 ferred to in section 208(b)(1) of title 18, United
19 States Code, a written certification as referred
20 to in section 208(b)(3) of title 18, United
21 States Code, or a waiver as referred to in sub-
22 paragraph (D)(iii) for service on the Commis-
23 sion at a meeting of the Commission.

24 "(C) DISCLOSURES; PROHIBITIONS ON
25 PARTICIPATION; WAIVERS.—

1 "(i) DISCLOSURE OF FINANCIAL IN-
2 TEREST.—Prior to a meeting of the Com-
3 mission or a clinical perspective advisory
4 panel described in paragraph (2)(H) re-
5 garding a 'particular matter' (as that term
6 is used in section 208 of title 18, United
7 States Code), each member of the Commis-
8 sion or the clinical perspective advisory
9 panel who is a full-time Government em-
10 ployee or special Government employee
11 shall disclose to the Secretary financial in-
12 terests in accordance with subsection (b) of
13 such section 208.
14 "(ii) PROHIBITIONS ON PARTICIPA-
15 TION.—Except as provided under clause
16 (iii), a member of the Commission or a
17 clinical perspective advisory panel de-
18 scribed in paragraph (2)(H) may not par-
19 ticipate with respect to a particular matter
20 considered in meeting of the Commission
21 or the clinical perspective advisory panel if
22 such member (or an immediate family
23 member of such member) has a financial
24 interest that could be affected by the ad-
25 vice given to the Secretary with respect to

1 such matter, excluding interests exempted
2 in regulations issued by the Director of the
3 Office of Government Ethics as too remote
4 or inconsequential to affect the integrity of
5 the services of the Government officers or
6 employees to which such regulations apply.
7 "(iii) WAIVER.—If the Secretary de-
8 termines it necessary to afford the Com-
9 mission or a clinical perspective advisory
10 panel described in paragraph 2(H) essen-
11 tial expertise, the Secretary may grant a
12 waiver of the prohibition in clause (ii) to
13 permit a member described in such sub-
14 paragraph to—
15 "(I) participate as a non-voting
16 member with respect to a particular
17 matter considered in a Commission or
18 a clinical perspective advisory panel
19 meeting; or
20 "(II) participate as a voting
21 member with respect to a particular
22 matter considered in a Commission or
23 a clinical perspective advisory panel
24 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

1 compensation at the per diem equivalent of the rate
2 provided for level IV of the Executive Schedule
3 under section 5315 of title 5, United States Code;
4 and while so serving away from home and the mem-
5 ber's regular place of business, a member may be al-
6 lowed travel expenses, as authorized by the Director
7 of the Commission.

8 ''(10) AVAILABILITY OF REPORTS.—The Com-
9 mission shall transmit to the Secretary a copy of
10 each report submitted under this subsection and
11 shall make such reports available to the public.

12 ''(11) DIRECTOR AND STAFF; EXPERTS AND
13 CONSULTANTS.—Subject to such review as the Sec-
14 retary deems necessary to assure the efficient ad-
15 ministration of the Commission, the Commission
16 may—

17 ''(A) appoint an Executive Director (sub-
18 ject to the approval of the Secretary) and such
19 other personnel as Federal employees under
20 section 2105 of title 5, United States Code, as
21 may be necessary to carry out its duties (with-
22 out regard to the provisions of title 5, United
23 States Code, governing appointments in the
24 competitive service);

1 "(B) seek such assistance and support as
2 may be required in the performance of its du-
3 ties from appropriate Federal departments and
4 agencies;
5 "(C) enter into contracts or make other ar-
6 rangements, as may be necessary for the con-
7 duct of the work of the Commission (without
8 regard to section 3709 of the Revised Statutes
9 (41 U.S.C. 5));
10 "(D) make advance, progress, and other
11 payments which relate to the work of the Com-
12 mission;
13 "(E) provide transportation and subsist-
14 ence for persons serving without compensation;
15 and
16 "(F) prescribe such rules and regulations
17 as it deems necessary with respect to the inter-
18 nal organization and operation of the Commis-
19 sion.
20 "(c) RESEARCH REQUIREMENTS.—Any research con-
21 ducted, supported, or synthesized under this section shall
22 meet the following requirements:
23 "(1) ENSURING TRANSPARENCY, CREDIBILITY,
24 AND ACCESS.—

1 "(A) The establishment of the agenda and
2 conduct of the research shall be insulated from
3 inappropriate political or stakeholder influence.
4 "(B) Methods of conducting such research
5 shall be scientifically based.
6 "(C) All aspects of the prioritization of re-
7 search, conduct of the research, and develop-
8 ment of conclusions based on the research shall
9 be transparent to all stakeholders.
10 "(D) The process and methods for con-
11 ducting such research shall be publicly docu-
12 mented and available to all stakeholders.
13 "(E) Throughout the process of such re-
14 search, the Center shall provide opportunities
15 for all stakeholders involved to review and pro-
16 vide public comment on the methods and find-
17 ings of such research.
18 "(2) USE OF CLINICAL PERSPECTIVE ADVISORY
19 PANELS.—The research shall meet a national re-
20 search priority determined under subsection
21 (b)(2)(A) and shall consider advice given to the Cen-
22 ter by the clinical perspective advisory panel for the
23 national research priority.
24 "(3) STAKEHOLDER INPUT.—

1 "(A) IN GENERAL.—The Commission shall
2 consult with patients, health care providers,
3 health care consumer representatives, and other
4 appropriate stakeholders with an interest in the
5 research through a transparent process rec-
6 ommended by the Commission.

7 "(B) SPECIFIC AREAS OF CONSULTA-
8 TION.—Consultation shall include where
9 deemed appropriate by the Commission—

10 "(i) recommending research priorities
11 and questions;

12 "(ii) recommending research meth-
13 odologies; and

14 "(iii) advising on and assisting with
15 efforts to disseminate research findings.

16 "(C) OMBUDSMAN.—The Secretary shall
17 designate a patient ombudsman. The ombuds-
18 man shall—

19 "(i) serve as an available point of con-
20 tact for any patients with an interest in
21 proposed comparative effectiveness studies
22 by the Center; and

23 "(ii) ensure that any comments from
24 patients regarding proposed comparative

1 effectiveness studies are reviewed by the
2 Commission.
3 "(4) TAKING INTO ACCOUNT POTENTIAL DIF-
4 FERENCES.—Research shall—
5 "(A) be designed, as appropriate, to take
6 into account the potential for differences in the
7 effectiveness of health care items and services
8 used with various subpopulations such as racial
9 and ethnic minorities, women, different age
10 groups (including children, adolescents, adults,
11 and seniors), and individuals with different
12 comorbidities; and—
13 "(B) seek, as feasible and appropriate, to
14 include members of such subpopulations as sub-
15 jects in the research.
16 "(d) PUBLIC ACCESS TO COMPARATIVE EFFECTIVE-
17 NESS INFORMATION.—
18 "(1) IN GENERAL.—Not later than 90 days
19 after receipt by the Center or Commission, as appli-
20 cable, of a relevant report described in paragraph
21 (2) made by the Center, Commission, or clinical per-
22 spective advisory panel under this section, appro-
23 priate information contained in such report shall be
24 posted on the official public Internet site of the Cen-
25 ter and of the Commission, as applicable.

1 "(2) RELEVANT REPORTS DESCRIBED.—For
2 purposes of this section, a relevant report is each of
3 the following submitted by the Center or a grantee
4 or contractor of the Center:
5 "(A) Any interim or progress reports as
6 deemed appropriate by the Secretary.
7 "(B) Stakeholder comments.
8 "(C) A final report.
9 "(e) DISSEMINATION AND INCORPORATION OF COM-
10 PARATIVE EFFECTIVENESS INFORMATION.—
11 "(1) DISSEMINATION.—The Center shall pro-
12 vide for the dissemination of appropriate findings
13 produced by research supported, conducted, or syn-
14 thesized under this section to health care providers,
15 patients, vendors of health information technology
16 focused on clinical decision support, appropriate pro-
17 fessional associations, and Federal and private
18 health plans, and other relevant stakeholders. In dis-
19 seminating such findings the Center shall—
20 "(A) convey findings of research so that
21 they are comprehensible and useful to patients
22 and providers in making health care decisions;
23 "(B) discuss findings and other consider-
24 ations specific to certain sub-populations, risk
25 factors, and comorbidities as appropriate;

1 "(C) include considerations such as limita-
2 tions of research and what further research
3 may be needed, as appropriate;
4 "(D) not include any data that the dis-
5 semination of which would violate the privacy of
6 research participants or violate any confiden-
7 tiality agreements made with respect to the use
8 of data under this section; and
9 "(E) assist the users of health information
10 technology focused on clinical decision support
11 to promote the timely incorporation of such
12 findings into clinical practices and promote the
13 ease of use of such incorporation.
14 "(2) DISSEMINATION PROTOCOLS AND STRATE-
15 GIES.—The Center shall develop protocols and strat-
16 egies for the appropriate dissemination of research
17 findings in order to ensure effective communication
18 of findings and the use and incorporation of such
19 findings into relevant activities for the purpose of in-
20 forming higher quality and more effective and effi-
21 cient decisions regarding medical items and services.
22 In developing and adopting such protocols and strat-
23 egies, the Center shall consult with stakeholders con-
24 cerning the types of dissemination that will be most
25 useful to the end users of information and may pro-

1 vide for the utilization of multiple formats for con-
2 veying findings to different audiences, including dis-
3 semination to individuals with limited English pro-
4 ficiency.

5 ‘‘(f) REPORTS TO CONGRESS.—

6 ‘‘(1) ANNUAL REPORTS.—Beginning not later
7 than one year after the date of the enactment of this
8 section, the Director of the Agency of Healthcare
9 Research and Quality and the Commission shall sub-
10 mit to Congress an annual report on the activities
11 of the Center and the Commission, as well as the re-
12 search, conducted under this section. Each such re-
13 port shall include a discussion of the Center's com-
14 pliance with subsection (c)(B)(4), including any rea-
15 sons for lack of complicance with such subsection.

16 ‘‘(2) RECOMMENDATION FOR FAIR SHARE PER
17 CAPITA AMOUNT FOR ALL-PAYER FINANCING.—Be-
18 ginning not later than December 31, 2011, the Sec-
19 retary shall submit to Congress an annual rec-
20 ommendation for a fair share per capita amount de-
21 scribed in subsection (c)(1) of section 9511 of the
22 Internal Revenue Code of 1986 for purposes of
23 funding the CERTF under such section.

24 ‘‘(3) ANALYSIS AND REVIEW.—Not later than
25 December 31, 2013, the Secretary, in consultation

1 with the Commission, shall submit to Congress a re-
2 port on all activities conducted or supported under
3 this section as of such date. Such report shall in-
4 clude an evaluation of the overall costs of such ac-
5 tivities and an analysis of the backlog of any re-
6 search proposals approved by the Commission but
7 not funded.

8 "(g) FUNDING OF COMPARATIVE EFFECTIVENESS
9 RESEARCH.—For fiscal year 2010 and each subsequent
10 fiscal year, amounts in the Comparative Effectiveness Re-
11 search Trust Fund (referred to in this section as the
12 'CERTF') under section 9511 of the Internal Revenue
13 Code of 1986 shall be available, without the need for fur-
14 ther appropriations and without fiscal year limitation, to
15 the Secretary to carry out this section.

16 "(h) CONSTRUCTION.—Nothing in this section shall
17 be construed to permit the Commission or the Center to
18 mandate coverage, reimbursement, or other policies for
19 any public or private payer.".

20 (b) COMPARATIVE EFFECTIVENESS RESEARCH
21 TRUST FUND; FINANCING FOR THE TRUST FUND.—For
22 provision establishing a Comparative Effectiveness Re-
23 search Trust Fund and financing such Trust Fund, see
24 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

1 ombudsman in the case where the Secretary,
2 the Inspector General, the State, or the State
3 long-term care ombudsman requests such infor-
4 mation; and

5 ''(B) beginning on the effective date of the
6 final regulations promulgated under paragraph
7 (4)(A), for reporting such information in ac-
8 cordance with such final regulations.

9 Nothing in subparagraph (A) shall be construed as
10 authorizing a facility to dispose of or delete informa-
11 tion described in such subparagraph after the effec-
12 tive date of the final regulations promulgated under
13 paragraph (4)(A).

14 ''(2) PUBLIC AVAILABILITY OF INFORMATION.—
15 During the period described in paragraph (1)(A), a
16 facility shall—

17 ''(A) make the information described in
18 paragraph (3) available to the public upon re-
19 quest and update such information as may be
20 necessary to reflect changes in such informa-
21 tion; and

22 ''(B) post a notice of the availability of
23 such information in the lobby of the facility in
24 a prominent manner.

25 ''(3) INFORMATION DESCRIBED.—

1 "(A) IN GENERAL.—The following infor-
2 mation is described in this paragraph:
3 "(i) The information described in sub-
4 sections (a) and (b), subject to subpara-
5 graph (C).
6 "(ii) The identity of and information
7 on—
8 "(I) each member of the gov-
9 erning body of the facility, including
10 the name, title, and period of service
11 of each such member;
12 "(II) each person or entity who is
13 an officer, director, member, partner,
14 trustee, or managing employee of the
15 facility, including the name, title, and
16 date of start of service of each such
17 person or entity; and
18 "(III) each person or entity who
19 is an additional disclosable party of
20 the facility.
21 "(iii) The organizational structure of
22 each person and entity described in sub-
23 clauses (II) and (III) of clause (ii) and a
24 description of the relationship of each such

1 person or entity to the facility and to one
2 another.
3 "(B) SPECIAL RULE WHERE INFORMATION
4 IS ALREADY REPORTED OR SUBMITTED.—To
5 the extent that information reported by a facil-
6 ity to the Internal Revenue Service on Form
7 990, information submitted by a facility to the
8 Securities and Exchange Commission, or infor-
9 mation otherwise submitted to the Secretary or
10 any other Federal agency contains the informa-
11 tion described in clauses (i), (ii), or (iii) of sub-
12 paragraph (A), the Secretary may allow, to the
13 extent practicable, such Form or such informa-
14 tion to meet the requirements of paragraph (1)
15 and to be submitted in a manner specified by
16 the Secretary.
17 "(C) SPECIAL RULE.—In applying sub-
18 paragraph (A)(i)—
19 "(i) with respect to subsections (a)
20 and (b), 'ownership or control interest'
21 shall include direct or indirect interests, in-
22 cluding such interests in intermediate enti-
23 ties; and
24 "(ii) subsection (a)(3)(A)(ii) shall in-
25 clude the owner of a whole or part interest

1 in any mortgage, deed of trust, note, or
2 other obligation secured, in whole or in
3 part, by the entity or any of the property
4 or assets thereof, if the interest is equal to
5 or exceeds 5 percent of the total property
6 or assets of the entirety.
7 ''(4) REPORTING.—
8 ''(A) IN GENERAL.—Not later than the
9 date that is 2 years after the date of the enact-
10 ment of this subsection, the Secretary shall pro-
11 mulgate regulations requiring, effective on the
12 date that is 90 days after the date on which
13 such final regulations are published in the Fed-
14 eral Register, a facility to report the informa-
15 tion described in paragraph (3) to the Secretary
16 in a standardized format, and such other regu-
17 lations as are necessary to carry out this sub-
18 section. Such final regulations shall ensure that
19 the facility certifies, as a condition of participa-
20 tion and payment under the program under
21 title XVIII or XIX, that the information re-
22 ported by the facility in accordance with such
23 final regulations is accurate and current.
24 ''(B) GUIDANCE.—The Secretary shall pro-
25 vide guidance and technical assistance to States

1 on how to adopt the standardized format under
2 subparagraph (A).
3 "(5) NO EFFECT ON EXISTING REPORTING RE-
4 QUIREMENTS.—Nothing in this subsection shall re-
5 duce, diminish, or alter any reporting requirement
6 for a facility that is in effect as of the date of the
7 enactment of this subsection.
8 "(6) DEFINITIONS.—In this subsection:
9 "(A) ADDITIONAL DISCLOSABLE PARTY.—
10 The term 'additional disclosable party' means,
11 with respect to a facility, any person or entity
12 who—
13 "(i) exercises operational, financial, or
14 managerial control over the facility or a
15 part thereof, or provides policies or proce-
16 dures for any of the operations of the facil-
17 ity, or provides financial or cash manage-
18 ment services to the facility;
19 "(ii) leases or subleases real property
20 to the facility, or owns a whole or part in-
21 terest equal to or exceeding 5 percent of
22 the total value of such real property;
23 "(iii) lends funds or provides a finan-
24 cial guarantee to the facility in an amount
25 which is equal to or exceeds $50,000; or

1 "(iv) provides management or admin-
2 istrative services, clinical consulting serv-
3 ices, or accounting or financial services to
4 the facility.
5 "(B) FACILITY.—The term 'facility' means
6 a disclosing entity which is—
7 "(i) a skilled nursing facility (as de-
8 fined in section 1819(a)); or
9 "(ii) a nursing facility (as defined in
10 section 1919(a)).
11 "(C) MANAGING EMPLOYEE.—The term
12 'managing employee' means, with respect to a
13 facility, an individual (including a general man-
14 ager, business manager, administrator, director,
15 or consultant) who directly or indirectly man-
16 ages, advises, or supervises any element of the
17 practices, finances, or operations of the facility.
18 "(D) ORGANIZATIONAL STRUCTURE.—The
19 term 'organizational structure' means, in the
20 case of—
21 "(i) a corporation, the officers, direc-
22 tors, and shareholders of the corporation
23 who have an ownership interest in the cor-
24 poration which is equal to or exceeds 5
25 percent;

1 "(ii) a limited liability company, the
2 members and managers of the limited li-
3 ability company (including, as applicable,
4 what percentage each member and man-
5 ager has of the ownership interest in the
6 limited liability company);
7 "(iii) a general partnership, the part-
8 ners of the general partnership;
9 "(iv) a limited partnership, the gen-
10 eral partners and any limited partners of
11 the limited partnership who have an own-
12 ership interest in the limited partnership
13 which is equal to or exceeds 10 percent;
14 "(v) a trust, the trustees of the trust;
15 "(vi) an individual, contact informa-
16 tion for the individual; and
17 "(vii) any other person or entity, such
18 information as the Secretary determines
19 appropriate.".
20 (b) PUBLIC AVAILABILITY OF INFORMATION.—
21 (1) IN GENERAL.—Not later than the date that
22 is 1 year after the date on which the final regula-
23 tions promulgated under section 1124(c)(4)(A) of
24 the Social Security Act, as added by subsection (a),
25 are published in the Federal Register, the informa-

1 tion reported in accordance with such final regula-
2 tions shall be made available to the public in accord-
3 ance with procedures established by the Secretary.
4 (2) DEFINITIONS.—In this subsection:
5 (A) NURSING FACILITY.—The term ''nurs-
6 ing facility'' has the meaning given such term
7 in section 1919(a) of the Social Security Act
8 (42 U.S.C. 1396r(a)).
9 (B) SECRETARY.—The term ''Secretary''
10 means the Secretary of Health and Human
11 Services.
12 (C) SKILLED NURSING FACILITY.—The
13 term ''skilled nursing facility'' has the meaning
14 given such term in section 1819(a) of the Social
15 Security Act (42 U.S.C. 1395i–3(a)).
16 (c) CONFORMING AMENDMENTS.—
17 (1) SKILLED NURSING FACILITIES.—Section
18 1819(d)(1) of the Social Security Act (42 U.S.C.
19 1395i–3(d)(1)) is amended by striking subparagraph
20 (B) and redesignating subparagraph (C) as subpara-
21 graph (B).
22 (2) NURSING FACILITIES.—Section 1919(d)(1)
23 of the Social Security Act (42 U.S.C. 1396r(d)(1))
24 is amended by striking subparagraph (B) and redes-
25 ignating subparagraph (C) as subparagraph (B).

1 **SEC. 1412. ACCOUNTABILITY REQUIREMENTS.**

2 (a) EFFECTIVE COMPLIANCE AND ETHICS PRO-
3 GRAMS.—

4 (1) SKILLED NURSING FACILITIES.—Section
5 1819(d)(1) of the Social Security Act (42 U.S.C.
6 1395i–3(d)(1)), as amended by section 1411(c)(1),
7 is amended by adding at the end the following new
8 subparagraph:

9 ''(C) COMPLIANCE AND ETHICS PRO-
10 GRAMS.—

11 ''(i) REQUIREMENT.—On or after the
12 date that is 36 months after the date of
13 the enactment of this subparagraph, a
14 skilled nursing facility shall, with respect
15 to the entity that operates the facility (in
16 this subparagraph referred to as the 'oper-
17 ating organization' or 'organization'), have
18 in operation a compliance and ethics pro-
19 gram that is effective in preventing and de-
20 tecting criminal, civil, and administrative
21 violations under this Act and in promoting
22 quality of care consistent with regulations
23 developed under clause (ii).

24 ''(ii) DEVELOPMENT OF REGULA-
25 TIONS.—

1 "(I) IN GENERAL.—Not later
2 than the date that is 2 years after
3 such date of the enactment, the Sec-
4 retary, in consultation with the In-
5 spector General of the Department of
6 Health and Human Services, shall
7 promulgate regulations for an effec-
8 tive compliance and ethics program
9 for operating organizations, which
10 may include a model compliance pro-
11 gram.
12 "(II) DESIGN OF REGULA-
13 TIONS.—Such regulations with respect
14 to specific elements or formality of a
15 program may vary with the size of the
16 organization, such that larger organi-
17 zations should have a more formal
18 and rigorous program and include es-
19 tablished written policies defining the
20 standards and procedures to be fol-
21 lowed by its employees. Such require-
22 ments shall specifically apply to the
23 corporate level management of multi-
24 unit nursing home chains.

1 "(III) EVALUATION.—Not later
2 than 3 years after the date of promul-
3 gation of regulations under this
4 clause, the Secretary shall complete
5 an evaluation of the compliance and
6 ethics programs required to be estab-
7 lished under this subparagraph. Such
8 evaluation shall determine if such pro-
9 grams led to changes in deficiency ci-
10 tations, changes in quality perform-
11 ance, or changes in other metrics of
12 resident quality of care. The Secretary
13 shall submit to Congress a report on
14 such evaluation and shall include in
15 such report such recommendations re-
16 garding changes in the requirements
17 for such programs as the Secretary
18 determines appropriate.
19 "(iii) REQUIREMENTS FOR COMPLI-
20 ANCE AND ETHICS PROGRAMS.—In this
21 subparagraph, the term 'compliance and
22 ethics program' means, with respect to a
23 skilled nursing facility, a program of the
24 operating organization that—

1 "(I) has been reasonably de-
2 signed, implemented, and enforced so
3 that it generally will be effective in
4 preventing and detecting criminal,
5 civil, and administrative violations
6 under this Act and in promoting qual-
7 ity of care; and
8 "(II) includes at least the re-
9 quired components specified in clause
10 (iv).
11 "(iv) REQUIRED COMPONENTS OF
12 PROGRAM.—The required components of a
13 compliance and ethics program of an orga-
14 nization are the following:
15 "(I) The organization must have
16 established compliance standards and
17 procedures to be followed by its em-
18 ployees, contractors, and other agents
19 that are reasonably capable of reduc-
20 ing the prospect of criminal, civil, and
21 administrative violations under this
22 Act.
23 "(II) Specific individuals within
24 high-level personnel of the organiza-
25 tion must have been assigned overall

1 responsibility to oversee compliance
2 with such standards and procedures
3 and have sufficient resources and au-
4 thority to assure such compliance.

5 "(III) The organization must
6 have used due care not to delegate
7 substantial discretionary authority to
8 individuals whom the organization
9 knew, or should have known through
10 the exercise of due diligence, had a
11 propensity to engage in criminal, civil,
12 and administrative violations under
13 this Act.

14 "(IV) The organization must
15 have taken steps to communicate ef-
16 fectively its standards and procedures
17 to all employees and other agents,
18 such as by requiring participation in
19 training programs or by disseminating
20 publications that explain in a practical
21 manner what is required.

22 "(V) The organization must have
23 taken reasonable steps to achieve com-
24 pliance with its standards, such as by
25 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

1 administrative violations under this
2 Act.
3 "(VIII) The organization must
4 periodically undertake reassessment of
5 its compliance program to identify
6 changes necessary to reflect changes
7 within the organization and its facili-
8 ties.
9 "(v) COORDINATION.—The provisions
10 of this subparagraph shall apply with re-
11 spect to a skilled nursing facility in lieu of
12 section 1874(d).".
13 (2) NURSING FACILITIES.—Section 1919(d)(1)
14 of the Social Security Act (42 U.S.C. 1396r(d)(1)),
15 as amended by section 1411(c)(2), is amended by
16 adding at the end the following new subparagraph:
17 "(C) COMPLIANCE AND ETHICS PRO-
18 GRAM.—
19 "(i) REQUIREMENT.—On or after the
20 date that is 36 months after the date of
21 the enactment of this subparagraph, a
22 nursing facility shall, with respect to the
23 entity that operates the facility (in this
24 subparagraph referred to as the 'operating
25 organization' or 'organization'), have in op-

1 eration a compliance and ethics program
2 that is effective in preventing and detect-
3 ing criminal, civil, and administrative viola-
4 tions under this Act and in promoting
5 quality of care consistent with regulations
6 developed under clause (ii).

7 "(ii) DEVELOPMENT OF REGULA-
8 TIONS.—

9 "(I) IN GENERAL.—Not later
10 than the date that is 2 years after
11 such date of the enactment, the Sec-
12 retary, in consultation with the In-
13 spector General of the Department of
14 Health and Human Services, shall de-
15 velop regulations for an effective com-
16 pliance and ethics program for oper-
17 ating organizations, which may in-
18 clude a model compliance program.

19 "(II) DESIGN OF REGULA-
20 TIONS.—Such regulations with respect
21 to specific elements or formality of a
22 program may vary with the size of the
23 organization, such that larger organi-
24 zations should have a more formal
25 and rigorous program and include es-

1 tablished written policies defining the
2 standards and procedures to be fol-
3 lowed by its employees. Such require-
4 ments may specifically apply to the
5 corporate level management of multi-
6 unit nursing home chains.

7 "(III) EVALUATION.—Not later
8 than 3 years after the date of promul-
9 gation of regulations under this clause
10 the Secretary shall complete an eval-
11 uation of the compliance and ethics
12 programs required to be established
13 under this subparagraph. Such eval-
14 uation shall determine if such pro-
15 grams led to changes in deficiency ci-
16 tations, changes in quality perform-
17 ance, or changes in other metrics of
18 resident quality of care. The Secretary
19 shall submit to Congress a report on
20 such evaluation and shall include in
21 such report such recommendations re-
22 garding changes in the requirements
23 for such programs as the Secretary
24 determines appropriate.

1 "(iii) REQUIREMENTS FOR COMPLI-
2 ANCE AND ETHICS PROGRAMS.—In this
3 subparagraph, the term 'compliance and
4 ethics program' means, with respect to a
5 nursing facility, a program of the oper-
6 ating organization that—
7 "(I) has been reasonably de-
8 signed, implemented, and enforced so
9 that it generally will be effective in
10 preventing and detecting criminal,
11 civil, and administrative violations
12 under this Act and in promoting qual-
13 ity of care; and
14 "(II) includes at least the re-
15 quired components specified in clause
16 (iv).
17 "(iv) REQUIRED COMPONENTS OF
18 PROGRAM.—The required components of a
19 compliance and ethics program of an orga-
20 nization are the following:
21 "(I) The organization must have
22 established compliance standards and
23 procedures to be followed by its em-
24 ployees and other agents that are rea-
25 sonably capable of reducing the pros-

1 pect of criminal, civil, and administra-
2 tive violations under this Act.
3 "(II) Specific individuals within
4 high-level personnel of the organiza-
5 tion must have been assigned overall
6 responsibility to oversee compliance
7 with such standards and procedures
8 and has sufficient resources and au-
9 thority to assure such compliance.
10 "(III) The organization must
11 have used due care not to delegate
12 substantial discretionary authority to
13 individuals whom the organization
14 knew, or should have known through
15 the exercise of due diligence, had a
16 propensity to engage in criminal, civil,
17 and administrative violations under
18 this Act.
19 "(IV) The organization must
20 have taken steps to communicate ef-
21 fectively its standards and procedures
22 to all employees and other agents,
23 such as by requiring participation in
24 training programs or by disseminating

1 publications that explain in a practical
2 manner what is required.
3 ‘‘(V) The organization must have
4 taken reasonable steps to achieve com-
5 pliance with its standards, such as by
6 utilizing monitoring and auditing sys-
7 tems reasonably designed to detect
8 criminal, civil, and administrative vio-
9 lations under this Act by its employ-
10 ees and other agents and by having in
11 place and publicizing a reporting sys-
12 tem whereby employees and other
13 agents could report violations by oth-
14 ers within the organization without
15 fear of retribution.
16 ‘‘(VI) The standards must have
17 been consistently enforced through ap-
18 propriate disciplinary mechanisms, in-
19 cluding, as appropriate, discipline of
20 individuals responsible for the failure
21 to detect an offense.
22 ‘‘(VII) After an offense has been
23 detected, the organization must have
24 taken all reasonable steps to respond
25 appropriately to the offense and to

1 prevent further similar offenses, in-
2 cluding repayment of any funds to
3 which it was not entitled and any nec-
4 essary modification to its program to
5 prevent and detect criminal, civil, and
6 administrative violations under this
7 Act.

8 "(VIII) The organization must
9 periodically undertake reassessment of
10 its compliance program to identify
11 changes necessary to reflect changes
12 within the organization and its facili-
13 ties.

14 "(v) COORDINATION.—The provisions
15 of this subparagraph shall apply with re-
16 spect to a nursing facility in lieu of section
17 1902(a)(77).".

18 (b) QUALITY ASSURANCE AND PERFORMANCE IM-
19 PROVEMENT PROGRAM.—

20 (1) SKILLED NURSING FACILITIES.—Section
21 1819(b)(1)(B) of the Social Security Act (42 U.S.C.
22 1396r(b)(1)(B)) is amended—

23 (A) by striking "ASSURANCE" and insert-
24 ing "ASSURANCE AND QUALITY ASSURANCE
25 AND PERFORMANCE IMPROVEMENT PROGRAM";

1 (B) by designating the matter beginning
2 with ''A nursing facility'' as a clause (i) with
3 the heading ''IN GENERAL.—'' and the appro-
4 priate indentation; and
5 (C) by adding at the end the following new
6 clause:
7 ''(ii) QUALITY ASSURANCE AND PER-
8 FORMANCE IMPROVEMENT PROGRAM.—
9 ''(I) IN GENERAL.—Not later
10 than December 31, 2011, the Sec-
11 retary shall establish and implement a
12 quality assurance and performance
13 improvement program (in this clause
14 referred to as the 'QAPI program')
15 for skilled nursing facilities, including
16 multi-unit chains of such facilities.
17 Under the QAPI program, the Sec-
18 retary shall establish standards relat-
19 ing to such facilities and provide tech-
20 nical assistance to such facilities on
21 the development of best practices in
22 order to meet such standards. Not
23 later than 1 year after the date on
24 which the regulations are promulgated
25 under subclause (II), a skilled nursing

1 facility must submit to the Secretary
2 a plan for the facility to meet such
3 standards and implement such best
4 practices, including how to coordinate
5 the implementation of such plan with
6 quality assessment and assurance ac-
7 tivities conducted under clause (i).
8 "(II) REGULATIONS.—The Sec-
9 retary shall promulgate regulations to
10 carry out this clause.".
11 (2) NURSING FACILITIES.—Section
12 1919(b)(1)(B) of the Social Security Act (42 U.S.C.
13 1396r(b)(1)(B)) is amended—
14 (A) by striking "ASSURANCE" and insert-
15 ing "ASSURANCE AND QUALITY ASSURANCE
16 AND PERFORMANCE IMPROVEMENT PROGRAM";
17 (B) by designating the matter beginning
18 with "A nursing facility" as a clause (i) with
19 the heading "IN GENERAL.—" and the appro-
20 priate indentation; and
21 (C) by adding at the end the following new
22 clause:
23 "(ii) QUALITY ASSURANCE AND PER-
24 FORMANCE IMPROVEMENT PROGRAM.—

1 "(I) IN GENERAL.—Not later
2 than December 31, 2011, the Sec-
3 retary shall establish and implement a
4 quality assurance and performance
5 improvement program (in this clause
6 referred to as the 'QAPI program')
7 for nursing facilities, including multi-
8 unit chains of such facilities. Under
9 the QAPI program, the Secretary
10 shall establish standards relating to
11 such facilities and provide technical
12 assistance to such facilities on the de-
13 velopment of best practices in order to
14 meet such standards. Not later than 1
15 year after the date on which the regu-
16 lations are promulgated under sub-
17 clause (II), a nursing facility must
18 submit to the Secretary a plan for the
19 facility to meet such standards and
20 implement such best practices, includ-
21 ing how to coordinate the implementa-
22 tion of such plan with quality assess-
23 ment and assurance activities con-
24 ducted under clause (i).

1 "(II) REGULATIONS.—The Sec-
2 retary shall promulgate regulations to
3 carry out this clause.".
4 (3) PROPOSAL TO REVISE QUALITY ASSURANCE
5 AND PERFORMANCE IMPROVEMENT PROGRAMS.—
6 The Secretary shall include in the proposed rule
7 published under section 1888(e) of the Social Secu-
8 rity Act (42 U.S.C. 1395yy(e)(5)(A)) for the subse-
9 quent fiscal year to the extent otherwise authorized
10 under section 1819(b)(1)(B) or 1819(d)(1)(C) of the
11 Social Security Act or other statutory or regulatory
12 authority, one or more proposals for skilled nursing
13 facilities to modify and strengthen quality assurance
14 and performance improvement programs in such fa-
15 cilities. At the time of publication of such proposed
16 rule and to the extent otherwise authorized under
17 section 1919(b)(1)(B) or 1919(d)(1)(C) of such Act
18 or other regulatory authority.
19 (4) FACILITY PLAN.—Not later than 1 year
20 after the date on which the regulations are promul-
21 gated under subclause (II) of clause (ii) of sections
22 1819(b)(1)(B) and 1919(b)(1)(B) of the Social Se-
23 curity Act, as added by paragraphs (1) and (2), a
24 skilled nursing facility and a nursing facility must
25 submit to the Secretary a plan for the facility to

1 meet the standards under such regulations and im-
2 plement such best practices, including how to coordi-
3 nate the implementation of such plan with quality
4 assessment and assurance activities conducted under
5 clause (i) of such sections.

6 (c) GAO STUDY ON NURSING FACILITY UNDER-
7 CAPITALIZATION.—

8 (1) IN GENERAL.—The Comptroller General of
9 the United States shall conduct a study that exam-
10 ines the following:

11 (A) The extent to which corporations that
12 own or operate large numbers of nursing facili-
13 ties, taking into account ownership type (includ-
14 ing private equity and control interests), are
15 undercapitalizing such facilities.

16 (B) The effects of such undercapitalization
17 on quality of care, including staffing and food
18 costs, at such facilities.

19 (C) Options to address such undercapital-
20 ization, such as requirements relating to surety
21 bonds, liability insurance, or minimum capital-
22 ization.

23 (2) REPORT.—Not later than 18 months after
24 the date of the enactment of this Act, the Comp-

1 troller General shall submit to Congress a report on
2 the study conducted under paragraph (1).
3 (3) NURSING FACILITY.—In this subsection, the
4 term ''nursing facility'' includes a skilled nursing fa-
5 cility.

6 **SEC. 1413. NURSING HOME COMPARE MEDICARE WEBSITE.**

7 (a) SKILLED NURSING FACILITIES.—
8 (1) IN GENERAL.—Section 1819 of the Social
9 Security Act (42 U.S.C. 1395i–3) is amended—
10 (A) by redesignating subsection (i) as sub-
11 section (j); and
12 (B) by inserting after subsection (h) the
13 following new subsection:
14 ''(i) NURSING HOME COMPARE WEBSITE.—
15 ''(1) INCLUSION OF ADDITIONAL INFORMA-
16 TION.—
17 ''(A) IN GENERAL.—The Secretary shall
18 ensure that the Department of Health and
19 Human Services includes, as part of the infor-
20 mation provided for comparison of nursing
21 homes on the official Internet website of the
22 Federal Government for Medicare beneficiaries
23 (commonly referred to as the 'Nursing Home
24 Compare' Medicare website) (or a successor
25 website), the following information in a manner

1 that is prominent, easily accessible, readily un-
2 derstandable to consumers of long-term care
3 services, and searchable:
4 "(i) Information that is reported to
5 the Secretary under section 1124(c)(4).
6 "(ii) Information on the 'Special
7 Focus Facility program' (or a successor
8 program) established by the Centers for
9 Medicare and Medicaid Services, according
10 to procedures established by the Secretary.
11 Such procedures shall provide for the in-
12 clusion of information with respect to, and
13 the names and locations of, those facilities
14 that, since the previous quarter—
15 "(I) were newly enrolled in the
16 program;
17 "(II) are enrolled in the program
18 and have failed to significantly im-
19 prove;
20 "(III) are enrolled in the pro-
21 gram and have significantly improved;
22 "(IV) have graduated from the
23 program; and
24 "(V) have closed voluntarily or
25 no longer participate under this title.

1 "(iii) Staffing data for each facility
2 (including resident census data and data
3 on the hours of care provided per resident
4 per day) based on data submitted under
5 subsection (b)(8)(C), including information
6 on staffing turnover and tenure, in a for-
7 mat that is clearly understandable to con-
8 sumers of long-term care services and al-
9 lows such consumers to compare dif-
10 ferences in staffing between facilities and
11 State and national averages for the facili-
12 ties. Such format shall include—
13 "(I) concise explanations of how
14 to interpret the data (such as a plain
15 English explanation of data reflecting
16 'nursing home staff hours per resident
17 day');
18 "(II) differences in types of staff
19 (such as training associated with dif-
20 ferent categories of staff);
21 "(III) the relationship between
22 nurse staffing levels and quality of
23 care; and

1 "(IV) an explanation that appro-
2 priate staffing levels vary based on
3 patient case mix.
4 "(iv) Links to State Internet websites
5 with information regarding State survey
6 and certification programs, links to Form
7 2567 State inspection reports (or a suc-
8 cessor form) on such websites, information
9 to guide consumers in how to interpret and
10 understand such reports, and the facility
11 plan of correction or other response to
12 such report.
13 "(v) The standardized complaint form
14 developed under subsection (f)(8), includ-
15 ing explanatory material on what com-
16 plaint forms are, how they are used, and
17 how to file a complaint with the State sur-
18 vey and certification program and the
19 State long-term care ombudsman program.
20 "(vi) Summary information on the
21 number, type, severity, and outcome of
22 substantiated complaints.
23 "(vii) The number of adjudicated in-
24 stances of criminal violations by employees
25 of a a nursing facility—

1 "(I) that were committed inside
2 the facility;
3 "(II) with respect to such in-
4 stances of violations or crimes com-
5 mitted inside of the facility that were
6 the violations or crimes of abuse, ne-
7 glect, and exploitation, criminal sexual
8 abuse, or other violations or crimes
9 that resulted in serious bodily injury;
10 and
11 "(III) the number of civil mone-
12 tary penalties levied against the facil-
13 ity, employees, contractors, and other
14 agents.
15 "(B) DEADLINE FOR PROVISION OF INFOR-
16 MATION.—
17 "(i) IN GENERAL.—Except as pro-
18 vided in clause (ii), the Secretary shall en-
19 sure that the information described in sub-
20 paragraph (A) is included on such website
21 (or a successor website) not later than 1
22 year after the date of the enactment of this
23 subsection.
24 "(ii) EXCEPTION.—The Secretary
25 shall ensure that the information described

1 in subparagraph (A)(i) and (A)(iii) is in-
2 cluded on such website (or a successor
3 website) not later than the date on which
4 the requirements under section 1124(c)(4)
5 and subsection (b)(8)(C)(ii) are imple-
6 mented.

7 ''(2) REVIEW AND MODIFICATION OF
8 WEBSITE.—

9 ''(A) IN GENERAL.—The Secretary shall
10 establish a process—

11 ''(i) to review the accuracy, clarity of
12 presentation, timeliness, and comprehen-
13 siveness of information reported on such
14 website as of the day before the date of the
15 enactment of this subsection; and

16 ''(ii) not later than 1 year after the
17 date of the enactment of this subsection, to
18 modify or revamp such website in accord-
19 ance with the review conducted under
20 clause (i).

21 ''(B) CONSULTATION.—In conducting the
22 review under subparagraph (A)(i), the Sec-
23 retary shall consult with—

24 ''(i) State long-term care ombudsman
25 programs;

1 “(ii) consumer advocacy groups;
2 “(iii) provider stakeholder groups; and
3 “(iv) any other representatives of pro-
4 grams or groups the Secretary determines
5 appropriate.”.
6 (2) TIMELINESS OF SUBMISSION OF SURVEY
7 AND CERTIFICATION INFORMATION.—
8 (A) IN GENERAL.—Section 1819(g)(5) of
9 the Social Security Act (42 U.S.C. 1395i–
10 3(g)(5)) is amended by adding at the end the
11 following new subparagraph:
12 “(E) SUBMISSION OF SURVEY AND CER-
13 TIFICATION INFORMATION TO THE SEC-
14 RETARY.—In order to improve the timeliness of
15 information made available to the public under
16 subparagraph (A) and provided on the Nursing
17 Home Compare Medicare website under sub-
18 section (i), each State shall submit information
19 respecting any survey or certification made re-
20 specting a skilled nursing facility (including any
21 enforcement actions taken by the State) to the
22 Secretary not later than the date on which the
23 State sends such information to the facility.
24 The Secretary shall use the information sub-
25 mitted under the preceding sentence to update

1 the information provided on the Nursing Home
2 Compare Medicare website as expeditiously as
3 practicable but not less frequently than quar-
4 terly.''.
5 (B) EFFECTIVE DATE.—The amendment
6 made by this paragraph shall take effect 1 year
7 after the date of the enactment of this Act.
8 (3) SPECIAL FOCUS FACILITY PROGRAM.—Sec-
9 tion 1819(f) of such Act is amended by adding at
10 the end the following new paragraph:
11 ''(8) SPECIAL FOCUS FACILITY PROGRAM.—
12 ''(A) IN GENERAL.—The Secretary shall
13 conduct a special focus facility program for en-
14 forcement of requirements for skilled nursing
15 facilities that the Secretary has identified as
16 having substantially failed to meet applicable
17 requirement of this Act.
18 ''(B) PERIODIC SURVEYS.—Under such
19 program the Secretary shall conduct surveys of
20 each facility in the program not less than once
21 every 6 months.''.
22 (b) NURSING FACILITIES.—
23 (1) IN GENERAL.—Section 1919 of the Social
24 Security Act (42 U.S.C. 1396r) is amended—

1 (A) by redesignating subsection (i) as sub-
2 section (j); and
3 (B) by inserting after subsection (h) the
4 following new subsection:
5 ''(i) NURSING HOME COMPARE WEBSITE.—
6 ''(1) INCLUSION OF ADDITIONAL INFORMA-
7 TION.—
8 ''(A) IN GENERAL.—The Secretary shall
9 ensure that the Department of Health and
10 Human Services includes, as part of the infor-
11 mation provided for comparison of nursing
12 homes on the official Internet website of the
13 Federal Government for Medicare beneficiaries
14 (commonly referred to as the 'Nursing Home
15 Compare' Medicare website) (or a successor
16 website), the following information in a manner
17 that is prominent, easily accessible, readily un-
18 derstandable to consumers of long-term care
19 services, and searchable:
20 ''(i) Staffing data for each facility (in-
21 cluding resident census data and data on
22 the hours of care provided per resident per
23 day) based on data submitted under sub-
24 section (b)(8)(C)(ii), including information
25 on staffing turnover and tenure, in a for-

1 mat that is clearly understandable to con-
2 sumers of long-term care services and al-
3 lows such consumers to compare dif-
4 ferences in staffing between facilities and
5 State and national averages for the facili-
6 ties. Such format shall include—
7 ''(I) concise explanations of how
8 to interpret the data (such as plain
9 English explanation of data reflecting
10 'nursing home staff hours per resident
11 day');
12 ''(II) differences in types of staff
13 (such as training associated with dif-
14 ferent categories of staff);
15 ''(III) the relationship between
16 nurse staffing levels and quality of
17 care; and
18 ''(IV) an explanation that appro-
19 priate staffing levels vary based on
20 patient case mix.
21 ''(ii) Links to State Internet websites
22 with information regarding State survey
23 and certification programs, links to Form
24 2567 State inspection reports (or a suc-
25 cessor form) on such websites, information

1 to guide consumers in how to interpret and
2 understand such reports, and the facility
3 plan of correction or other response to
4 such report.
5 "(iii) The standardized complaint
6 form developed under subsection (f)(10),
7 including explanatory material on what
8 complaint forms are, how they are used,
9 and how to file a complaint with the State
10 survey and certification program and the
11 State long-term care ombudsman program.
12 "(iv) Summary information on the
13 number, type, severity, and outcome of
14 substantiated complaints.
15 "(v) The number of adjudicated in-
16 stances of criminal violations by employees
17 of a nursing facility—
18 "(I) that were committed inside
19 of the facility; and
20 "(II) with respect to such in-
21 stances of violations or crimes com-
22 mitted outside of the facility, that
23 were the violations or crimes that re-
24 sulted in the serious bodily injury of
25 an elder.

1 "(B) DEADLINE FOR PROVISION OF INFOR-
2 MATION.—
3 "(i) IN GENERAL.—Except as pro-
4 vided in clause (ii), the Secretary shall en-
5 sure that the information described in sub-
6 paragraph (A) is included on such website
7 (or a successor website) not later than 1
8 year after the date of the enactment of this
9 subsection.
10 "(ii) EXCEPTION.—The Secretary
11 shall ensure that the information described
12 in subparagraph (A)(i) and (A)(iii) is in-
13 cluded on such website (or a successor
14 website) not later than the date on which
15 the requirements under section 1124(c)(4)
16 and subsection (b)(8)(C)(ii) are imple-
17 mented.
18 "(2) REVIEW AND MODIFICATION OF
19 WEBSITE.—
20 "(A) IN GENERAL.—The Secretary shall
21 establish a process—
22 "(i) to review the accuracy, clarity of
23 presentation, timeliness, and comprehen-
24 siveness of information reported on such

1 website as of the day before the date of the
2 enactment of this subsection; and
3 ''(ii) not later than 1 year after the
4 date of the enactment of this subsection, to
5 modify or revamp such website in accord-
6 ance with the review conducted under
7 clause (i).
8 ''(B) CONSULTATION.—In conducting the
9 review under subparagraph (A)(i), the Sec-
10 retary shall consult with—
11 ''(i) State long-term care ombudsman
12 programs;
13 ''(ii) consumer advocacy groups;
14 ''(iii) provider stakeholder groups;
15 ''(iv) skilled nursing facility employees
16 and their representatives; and
17 ''(v) any other representatives of pro-
18 grams or groups the Secretary determines
19 appropriate.''.
20 (2) TIMELINESS OF SUBMISSION OF SURVEY
21 AND CERTIFICATION INFORMATION.—
22 (A) IN GENERAL.—Section 1919(g)(5) of
23 the Social Security Act (42 U.S.C. 1396r(g)(5))
24 is amended by adding at the end the following
25 new subparagraph:

1 "(E) SUBMISSION OF SURVEY AND CER-
2 TIFICATION INFORMATION TO THE SEC-
3 RETARY.—In order to improve the timeliness of
4 information made available to the public under
5 subparagraph (A) and provided on the Nursing
6 Home Compare Medicare website under sub-
7 section (i), each State shall submit information
8 respecting any survey or certification made re-
9 specting a nursing facility (including any en-
10 forcement actions taken by the State) to the
11 Secretary not later than the date on which the
12 State sends such information to the facility.
13 The Secretary shall use the information sub-
14 mitted under the preceding sentence to update
15 the information provided on the Nursing Home
16 Compare Medicare website as expeditiously as
17 practicable but not less frequently than quar-
18 terly.".
19 (B) EFFECTIVE DATE.—The amendment
20 made by this paragraph shall take effect 1 year
21 after the date of the enactment of this Act.
22 (3) SPECIAL FOCUS FACILITY PROGRAM.—Sec-
23 tion 1919(f) of such Act is amended by adding at
24 the end of the following new paragraph:
25 "(10) SPECIAL FOCUS FACILITY PROGRAM.—

1 "(A) IN GENERAL.—The Secretary shall
2 conduct a special focus facility program for en-
3 forcement of requirements for nursing facilities
4 that the Secretary has identified as having sub-
5 stantially failed to meet applicable requirements
6 of this Act.

7 "(B) PERIODIC SURVEYS.—Under such
8 program the Secretary shall conduct surveys of
9 each facility in the program not less often than
10 once every 6 months.".

11 (c) AVAILABILITY OF REPORTS ON SURVEYS, CER-
12 TIFICATIONS, AND COMPLAINT INVESTIGATIONS.—

13 (1) SKILLED NURSING FACILITIES.—Section
14 1819(d)(1) of the Social Security Act (42 U.S.C.
15 1395i–3(d)(1)), as amended by sections 1411 and
16 1412, is amended by adding at the end the following
17 new subparagraph:

18 "(D) AVAILABILITY OF SURVEY, CERTIFI-
19 CATION, AND COMPLAINT INVESTIGATION RE-
20 PORTS.—A skilled nursing facility must—

21 "(i) have reports with respect to any
22 surveys, certifications, and complaint in-
23 vestigations made respecting the facility
24 during the 3 preceding years available for
25 any individual to review upon request; and

1 "(ii) post notice of the availability of
2 such reports in areas of the facility that
3 are prominent and accessible to the public.
4 The facility shall not make available under
5 clause (i) identifying information about com-
6 plainants or residents.".
7 (2) NURSING FACILITIES.—Section 1919(d)(1)
8 of the Social Security Act (42 U.S.C. 1396r(d)(1)),
9 as amended by sections 1411 and 1412, is amended
10 by adding at the end the following new subpara-
11 graph:
12 "(D) AVAILABILITY OF SURVEY, CERTIFI-
13 CATION, AND COMPLAINT INVESTIGATION RE-
14 PORTS.—A nursing facility must—
15 "(i) have reports with respect to any
16 surveys, certifications, and complaint in-
17 vestigations made respecting the facility
18 during the 3 preceding years available for
19 any individual to review upon request; and
20 "(ii) post notice of the availability of
21 such reports in areas of the facility that
22 are prominent and accessible to the public.
23 The facility shall not make available under
24 clause (i) identifying information about com-
25 plainants or residents.".

1 (3) EFFECTIVE DATE.—The amendments made
2 by this subsection shall take effect 1 year after the
3 date of the enactment of this Act.
4 (d) GUIDANCE TO STATES ON FORM 2567 STATE IN-
5 SPECTION REPORTS AND COMPLAINT INVESTIGATION RE-
6 PORTS.—
7 (1) GUIDANCE.—The Secretary of Health and
8 Human Services (in this subtitle referred to as the
9 "Secretary") shall provide guidance to States on
10 how States can establish electronic links to Form
11 2567 State inspection reports (or a successor form),
12 complaint investigation reports, and a facility's plan
13 of correction or other response to such Form 2567
14 State inspection reports (or a successor form) on the
15 Internet website of the State that provides informa-
16 tion on skilled nursing facilities and nursing facili-
17 ties and the Secretary shall, if possible, include such
18 information on Nursing Home Compare.
19 (2) REQUIREMENT.—Section 1902(a)(9) of the
20 Social Security Act (42 U.S.C. 1396a(a)(9)) is
21 amended—
22 (A) by striking "and" at the end of sub-
23 paragraph (B);
24 (B) by striking the semicolon at the end of
25 subparagraph (C) and inserting ", and"; and

1 (C) by adding at the end the following new
2 subparagraph:
3 ''(D) that the State maintain a consumer-
4 oriented website providing useful information to
5 consumers regarding all skilled nursing facili-
6 ties and all nursing facilities in the State, in-
7 cluding for each facility, Form 2567 State in-
8 spection reports (or a successor form), com-
9 plaint investigation reports, the facility's plan of
10 correction, and such other information that the
11 State or the Secretary considers useful in as-
12 sisting the public to assess the quality of long
13 term care options and the quality of care pro-
14 vided by individual facilities;''.
15 (3) DEFINITIONS.—In this subsection:
16 (A) NURSING FACILITY.—The term ''nurs-
17 ing facility'' has the meaning given such term
18 in section 1919(a) of the Social Security Act
19 (42 U.S.C. 1396r(a)).
20 (B) SECRETARY.—The term ''Secretary''
21 means the Secretary of Health and Human
22 Services.
23 (C) SKILLED NURSING FACILITY.—The
24 term ''skilled nursing facility'' has the meaning

1 given such term in section 1819(a) of the Social
2 Security Act (42 U.S.C. 1395i–3(a)).
3 **SEC. 1414. REPORTING OF EXPENDITURES.**
4 Section 1888 of the Social Security Act (42 U.S.C.
5 1395yy) is amended by adding at the end the following
6 new subsection:
7 ''(f) REPORTING OF DIRECT CARE EXPENDI-
8 TURES.—
9 ''(1) IN GENERAL.—For cost reports submitted
10 under this title for cost reporting periods beginning
11 on or after the date that is 3 years after the date
12 of the enactment of this subsection, skilled nursing
13 facilities shall separately report expenditures for
14 wages and benefits for direct care staff (breaking
15 out (at a minimum) registered nurses, licensed pro-
16 fessional nurses, certified nurse assistants, and other
17 medical and therapy staff).
18 ''(2) MODIFICATION OF FORM.—The Secretary,
19 in consultation with private sector accountants expe-
20 rienced with skilled nursing facility cost reports,
21 shall redesign such reports to meet the requirement
22 of paragraph (1) not later than 1 year after the date
23 of the enactment of this subsection.
24 ''(3) CATEGORIZATION BY FUNCTIONAL AC-
25 COUNTS.—Not later than 30 months after the date

1 of the enactment of this subsection, the Secretary,
2 working in consultation with the Medicare Payment
3 Advisory Commission, the Inspector General of the
4 Department of Health and Human Services, and
5 other expert parties the Secretary determines appro-
6 priate, shall take the expenditures listed on cost re-
7 ports, as modified under paragraph (1), submitted
8 by skilled nursing facilities and categorize such ex-
9 penditures, regardless of any source of payment for
10 such expenditures, for each skilled nursing facility
11 into the following functional accounts on an annual
12 basis:
13 ''(A) Spending on direct care services (in-
14 cluding nursing, therapy, and medical services).
15 ''(B) Spending on indirect care (including
16 housekeeping and dietary services).
17 ''(C) Capital assets (including building and
18 land costs).
19 ''(D) Administrative services costs.
20 ''(4) AVAILABILITY OF INFORMATION SUB-
21 MITTED.—The Secretary shall establish procedures
22 to make information on expenditures submitted
23 under this subsection readily available to interested
24 parties upon request, subject to such requirements

1 as the Secretary may specify under the procedures
2 established under this paragraph.''.

3 **SEC. 1415. STANDARDIZED COMPLAINT FORM.**

4 (a) SKILLED NURSING FACILITIES.—
5 (1) DEVELOPMENT BY THE SECRETARY.—Sec-
6 tion 1819(f) of the Social Security Act (42 U.S.C.
7 1395i–3(f)), as amended by section 1413(a)(3), is
8 amended by adding at the end the following new
9 paragraph:
10 ''(9) STANDARDIZED COMPLAINT FORM.—The
11 Secretary shall develop a standardized complaint
12 form for use by a resident (or a person acting on the
13 resident's behalf) in filing a complaint with a State
14 survey and certification agency and a State long-
15 term care ombudsman program with respect to a
16 skilled nursing facility.''.
17 (2) STATE REQUIREMENTS.—Section 1819(e)
18 of the Social Security Act (42 U.S.C. 1395i–3(e)) is
19 amended by adding at the end the following new
20 paragraph:
21 ''(6) COMPLAINT PROCESSES AND WHISTLE-
22 BLOWER PROTECTION.—
23 ''(A) COMPLAINT FORMS.—The State must
24 make the standardized complaint form devel-

1 oped under subsection (f)(9) available upon re-
2 quest to—
3 ‘‘(i) a resident of a skilled nursing fa-
4 cility;
5 ‘‘(ii) any person acting on the resi-
6 dent's behalf; and
7 ‘‘(iii) any person who works at a
8 skilled nursing facility or is a representa-
9 tive of such a worker.
10 ‘‘(B) COMPLAINT RESOLUTION PROCESS.—
11 The State must establish a complaint resolution
12 process in order to ensure that a resident, the
13 legal representative of a resident of a skilled
14 nursing facility, or other responsible party is
15 not retaliated against if the resident, legal rep-
16 resentative, or responsible party has com-
17 plained, in good faith, about the quality of care
18 or other issues relating to the skilled nursing
19 facility, that the legal representative of a resi-
20 dent of a skilled nursing facility or other re-
21 sponsible party is not denied access to such
22 resident or otherwise retaliated against if such
23 representative party has complained, in good
24 faith, about the quality of care provided by the
25 facility or other issues relating to the facility,

1 and that a person who works at a skilled nurs-
2 ing facility is not retaliated against if the work-
3 er has complained, in good faith, about quality
4 of care or services or an issue relating to the
5 quality of care or services provided at the facil-
6 ity, whether the resident, legal representative,
7 other responsible party, or worker used the
8 form developed under subsection (f)(9) or some
9 other method for submitting the complaint.
10 Such complaint resolution process shall in-
11 clude—

12 ''(i) procedures to assure accurate
13 tracking of complaints received, including
14 notification to the complainant that a com-
15 plaint has been received;

16 ''(ii) procedures to determine the like-
17 ly severity of a complaint and for the in-
18 vestigation of the complaint;

19 ''(iii) deadlines for responding to a
20 complaint and for notifying the complain-
21 ant of the outcome of the investigation;
22 and

23 ''(iv) procedures to ensure that the
24 identity of the complainant will be kept
25 confidential.

1 "(C) WHISTLEBLOWER PROTECTION.—
2 "(i) PROHIBITION AGAINST RETALIA-
3 TION.—No person who works at a skilled
4 nursing facility may be penalized, discrimi-
5 nated, or retaliated against with respect to
6 any aspect of employment, including dis-
7 charge, promotion, compensation, terms,
8 conditions, or privileges of employment, or
9 have a contract for services terminated, be-
10 cause the person (or anyone acting at the
11 person's request) complained, in good
12 faith, about the quality of care or services
13 provided by a nursing facility or about
14 other issues relating to quality of care or
15 services, whether using the form developed
16 under subsection (f)(9) or some other
17 method for submitting the complaint.
18 "(ii) RETALIATORY REPORTING.—A
19 skilled nursing facility may not file a com-
20 plaint or a report against a person who
21 works (or has worked at the facility with
22 the appropriate State professional discipli-
23 nary agency because the person (or anyone
24 acting at the person's request) complained
25 in good faith, as described in clause (i).

1 "(iii) COMMENCEMENT OF ACTION.—
2 Any person who believes the person has
3 been penalized, discriminated , or retali-
4 ated against or had a contract for services
5 terminated in violation of clause (i) or
6 against whom a complaint has been filed in
7 violation of clause (ii) may bring an action
8 at law or equity in the appropriate district
9 court of the United States, which shall
10 have jurisdiction over such action without
11 regard to the amount in controversy or the
12 citizenship of the parties, and which shall
13 have jurisdiction to grant complete relief,
14 including, but not limited to, injunctive re-
15 lief (such as reinstatement, compensatory
16 damages (which may include reimburse-
17 ment of lost wages, compensation, and
18 benefits), costs of litigation (including rea-
19 sonable attorney and expert witness fees),
20 exemplary damages where appropriate, and
21 such other relief as the court deems just
22 and proper.
23 "(iv) RIGHTS NOT WAIVABLE.—The
24 rights protected by this paragraph may not
25 be diminished by contract or other agree-

1 ment, and nothing in this paragraph shall
2 be construed to diminish any greater or
3 additional protection provided by Federal
4 or State law or by contract or other agree-
5 ment.
6 "(v) REQUIREMENT TO POST NOTICE
7 OF EMPLOYEE RIGHTS.—Each skilled
8 nursing facility shall post conspicuously in
9 an appropriate location a sign (in a form
10 specified by the Secretary) specifying the
11 rights of persons under this paragraph and
12 including a statement that an employee
13 may file a complaint with the Secretary
14 against a skilled nursing facility that vio-
15 lates the provisions of this paragraph and
16 information with respect to the manner of
17 filing such a complaint.
18 "(D) RULE OF CONSTRUCTION.—Nothing
19 in this paragraph shall be construed as pre-
20 venting a resident of a skilled nursing facility
21 (or a person acting on the resident's behalf)
22 from submitting a complaint in a manner or
23 format other than by using the standardized
24 complaint form developed under subsection
25 (f)(9) (including submitting a complaint orally).

1 "(E) GOOD FAITH DEFINED.—For pur-
2 poses of this paragraph, an individual shall be
3 deemed to be acting in good faith with respect
4 to the filing of a complaint if the individual rea-
5 sonably believes—
6 "(i) the information reported or dis-
7 closed in the complaint is true; and
8 "(ii) the violation of this title has oc-
9 curred or may occur in relation to such in-
10 formation.".
11 (b) NURSING FACILITIES.—
12 (1) DEVELOPMENT BY THE SECRETARY.—Sec-
13 tion 1919(f) of the Social Security Act (42 U.S.C.
14 1395i–3(f)), as amended by section 1413(b), is
15 amended by adding at the end the following new
16 paragraph:
17 "(11) STANDARDIZED COMPLAINT FORM.—The
18 Secretary shall develop a standardized complaint
19 form for use by a resident (or a person acting on the
20 resident's behalf) in filing a complaint with a State
21 survey and certification agency and a State long-
22 term care ombudsman program with respect to a
23 nursing facility.".
24 (2) STATE REQUIREMENTS.—Section 1919(e)
25 of the Social Security Act (42 U.S.C. 1395i–3(e)) is

1 amended by adding at the end the following new
2 paragraph:
3 "(8) COMPLAINT PROCESSES AND WHISTLE-
4 BLOWER PROTECTION.—
5 "(A) COMPLAINT FORMS.—The State must
6 make the standardized complaint form devel-
7 oped under subsection (f)(11) available upon re-
8 quest to—
9 "(i) a resident of a nursing facility;
10 "(ii) any person acting on the resi-
11 dent's behalf; and
12 "(iii) any person who works at a nurs-
13 ing facility or a representative of such a
14 worker.
15 "(B) COMPLAINT RESOLUTION PROCESS.—
16 The State must establish a complaint resolution
17 process in order to ensure that a resident, the
18 legal representative of a resident of a nursing
19 facility, or other responsible party is not retali-
20 ated against if the resident, legal representa-
21 tive, or responsible party has complained, in
22 good faith, about the quality of care or other
23 issues relating to the nursing facility, that the
24 legal representative of a resident of a nursing
25 facility or other responsible party is not denied

1 access to such resident or otherwise retaliated
2 against if such representative party has com-
3 plained, in good faith, about the quality of care
4 provided by the facility or other issues relating
5 to the facility, and that a person who works at
6 a nursing facility is not retaliated against if the
7 worker has complained, in good faith, about
8 quality of care or services or an issue relating
9 to the quality of care or services provided at the
10 facility, whether the resident, legal representa-
11 tive, other responsible party, or worker used the
12 form developed under subsection (f)(11) or
13 some other method for submitting the com-
14 plaint. Such complaint resolution process shall
15 include—
16 ''(i) procedures to assure accurate
17 tracking of complaints received, including
18 notification to the complainant that a com-
19 plaint has been received;
20 ''(ii) procedures to determine the like-
21 ly severity of a complaint and for the in-
22 vestigation of the complaint;
23 ''(iii) deadlines for responding to a
24 complaint and for notifying the complain-

1 ant of the outcome of the investigation;
2 and
3 "(iv) procedures to ensure that the
4 identity of the complainant will be kept
5 confidential.
6 "(C) WHISTLEBLOWER PROTECTION.—
7 "(i) PROHIBITION AGAINST RETALIA-
8 TION.—No person who works at a nursing
9 facility may be penalized, discriminated, or
10 retaliated against with respect to any as-
11 pect of employment, including discharge,
12 promotion, compensation, terms, condi-
13 tions, or privileges of employment, or have
14 a contract for services terminated, because
15 the person (or anyone acting at the per-
16 son's request) complained, in good faith,
17 about the quality of care or services pro-
18 vided by a nursing facility or about other
19 issues relating to quality of care or serv-
20 ices, whether using the form developed
21 under subsection (f)(11) or some other
22 method for submitting the complaint.
23 "(ii) RETALIATORY REPORTING.—A
24 nursing facility may not file a complaint or
25 a report against a person who works (or

1 has worked at the facility with the appro-
2 priate State professional disciplinary agen-
3 cy because the person (or anyone acting at
4 the person's request) complained in good
5 faith, as described in clause (i).
6 "(iii) COMMENCEMENT OF ACTION.—
7 Any person who believes the person has
8 been penalized, discriminated, or retaliated
9 against or had a contract for services ter-
10 minated in violation of clause (i) or against
11 whom a complaint has been filed in viola-
12 tion of clause (ii) may bring an action at
13 law or equity in the appropriate district
14 court of the United States, which shall
15 have jurisdiction over such action without
16 regard to the amount in controversy or the
17 citizenship of the parties, and which shall
18 have jurisdiction to grant complete relief,
19 including, but not limited to, injunctive re-
20 lief (such as reinstatement, compensatory
21 damages (which may include reimburse-
22 ment of lost wages, compensation, and
23 benefits), costs of litigation (including rea-
24 sonable attorney and expert witness fees),
25 exemplary damages where appropriate, and

1 such other relief as the court deems just
2 and proper.
3 "(iv) RIGHTS NOT WAIVABLE.—The
4 rights protected by this paragraph may not
5 be diminished by contract or other agree-
6 ment, and nothing in this paragraph shall
7 be construed to diminish any greater or
8 additional protection provided by Federal
9 or State law or by contract or other agree-
10 ment.
11 "(v) REQUIREMENT TO POST NOTICE
12 OF EMPLOYEE RIGHTS.—Each nursing fa-
13 cility shall post conspicuously in an appro-
14 priate location a sign (in a form specified
15 by the Secretary) specifying the rights of
16 persons under this paragraph and includ-
17 ing a statement that an employee may file
18 a complaint with the Secretary against a
19 nursing facility that violates the provisions
20 of this paragraph and information with re-
21 spect to the manner of filing such a com-
22 plaint.
23 "(D) RULE OF CONSTRUCTION.—Nothing
24 in this paragraph shall be construed as pre-
25 venting a resident of a nursing facility (or a

1 person acting on the resident's behalf) from
2 submitting a complaint in a manner or format
3 other than by using the standardized complaint
4 form developed under subsection (f)(11) (in-
5 cluding submitting a complaint orally).

6 "(E) GOOD FAITH DEFINED.—For pur-
7 poses of this paragraph, an individual shall be
8 deemed to be acting in good faith with respect
9 to the filing of a complaint if the individual rea-
10 sonably believes—

11 "(i) the information reported or dis-
12 closed in the complaint is true; and

13 "(ii) the violation of this title has oc-
14 curred or may occur in relation to such in-
15 formation.".

16 (c) EFFECTIVE DATE.—The amendments made by
17 this section shall take effect 1 year after the date of the
18 enactment of this Act.

19 **SEC. 1416. ENSURING STAFFING ACCOUNTABILITY.**

20 (a) SKILLED NURSING FACILITIES.—Section
21 1819(b)(8) of the Social Security Act (42 U.S.C. 1395i–
22 3(b)(8)) is amended by adding at the end the following
23 new subparagraph:

24 "(C) SUBMISSION OF STAFFING INFORMA-
25 TION BASED ON PAYROLL DATA IN A UNIFORM

1 FORMAT.—Beginning not later than 2 years
2 after the date of the enactment of this subpara-
3 graph, and after consulting with State long-
4 term care ombudsman programs, consumer ad-
5 vocacy groups, provider stakeholder groups, em-
6 ployees and their representatives, and other
7 parties the Secretary deems appropriate, the
8 Secretary shall require a skilled nursing facility
9 to electronically submit to the Secretary direct
10 care staffing information (including information
11 with respect to agency and contract staff) based
12 on payroll and other verifiable and auditable
13 data in a uniform format (according to speci-
14 fications established by the Secretary in con-
15 sultation with such programs, groups, and par-
16 ties). Such specifications shall require that the
17 information submitted under the preceding sen-
18 tence—
19 ''(i) specify the category of work a
20 certified employee performs (such as
21 whether the employee is a registered nurse,
22 licensed practical nurse, licensed vocational
23 nurse, certified nursing assistant, thera-
24 pist, or other medical personnel);

1 "(ii) include resident census data and
2 information on resident case mix;
3 "(iii) include a regular reporting
4 schedule; and
5 "(iv) include information on employee
6 turnover and tenure and on the hours of
7 care provided by each category of certified
8 employees referenced in clause (i) per resi-
9 dent per day.
10 Nothing in this subparagraph shall be con-
11 strued as preventing the Secretary from requir-
12 ing submission of such information with respect
13 to specific categories, such as nursing staff, be-
14 fore other categories of certified employees. In-
15 formation under this subparagraph with respect
16 to agency and contract staff shall be kept sepa-
17 rate from information on employee staffing.".
18 (b) NURSING FACILITIES.—Section 1919(b)(8) of the
19 Social Security Act (42 U.S.C. 1396r(b)(8)) is amended
20 by adding at the end the following new subparagraph:
21 "(C) SUBMISSION OF STAFFING INFORMA-
22 TION BASED ON PAYROLL DATA IN A UNIFORM
23 FORMAT.—Beginning not later than 2 years
24 after the date of the enactment of this subpara-
25 graph, and after consulting with State long-

1 term care ombudsman programs, consumer ad-
2 vocacy groups, provider stakeholder groups, em-
3 ployees and their representatives, and other
4 parties the Secretary deems appropriate, the
5 Secretary shall require a nursing facility to elec-
6 tronically submit to the Secretary direct care
7 staffing information (including information with
8 respect to agency and contract staff) based on
9 payroll and other verifiable and auditable data
10 in a uniform format (according to specifications
11 established by the Secretary in consultation
12 with such programs, groups, and parties). Such
13 specifications shall require that the information
14 submitted under the preceding sentence—
15 ''(i) specify the category of work a
16 certified employee performs (such as
17 whether the employee is a registered nurse,
18 licensed practical nurse, licensed vocational
19 nurse, certified nursing assistant, thera-
20 pist, or other medical personnel);
21 ''(ii) include resident census data and
22 information on resident case mix;
23 ''(iii) include a regular reporting
24 schedule; and

1 "(iv) include information on employee
2 turnover and tenure and on the hours of
3 care provided by each category of certified
4 employees referenced in clause (i) per resi-
5 dent per day.

6 Nothing in this subparagraph shall be con-
7 strued as preventing the Secretary from requir-
8 ing submission of such information with respect
9 to specific categories, such as nursing staff, be-
10 fore other categories of certified employees. In-
11 formation under this subparagraph with respect
12 to agency and contract staff shall be kept sepa-
13 rate from information on employee staffing.".

14 **PART 2—TARGETING ENFORCEMENT**

15 **SEC. 1421. CIVIL MONEY PENALTIES.**

16 (a) SKILLED NURSING FACILITIES.—
17 (1) IN GENERAL.—Section 1819(h)(2)(B)(ii) of
18 the Social Security Act (42 U.S.C. 1395i–
19 3(h)(2)(B)(ii)) is amended to read as follows:
20 "(ii) AUTHORITY WITH RESPECT TO
21 CIVIL MONEY PENALTIES.—
22 "(I) AMOUNT.—The Secretary
23 may impose a civil money penalty in
24 the applicable per instance or per day
25 amount (as defined in subclause (II)

1 and (III)) for each day or instance,
2 respectively, of noncompliance (as de-
3 termined appropriate by the Sec-
4 retary).

5 ''(II) APPLICABLE PER INSTANCE
6 AMOUNT.—In this clause, the term
7 'applicable per instance amount'
8 means—

9 ''(aa) in the case where the
10 deficiency is found to be a direct
11 proximate cause of death of a
12 resident of the facility, an
13 amount not to exceed $100,000.

14 ''(bb) in each case of a defi-
15 ciency where the facility is cited
16 for actual harm or immediate
17 jeopardy, an amount not less
18 than $3,050 and not more than
19 $25,000; and

20 ''(cc) in each case of any
21 other deficiency, an amount not
22 less than $250 and not to exceed
23 $3050.

1 "(III) APPLICABLE PER DAY
2 AMOUNT.—In this clause, the term
3 'applicable per day amount' means—
4 "(aa) in each case of a defi-
5 ciency where the facility is cited
6 for actual harm or immediate
7 jeopardy, an amount not less
8 than $3,050 and not more than
9 $25,000 and
10 "(bb) in each case of any
11 other deficiency, an amount not
12 less than $250 and not to exceed
13 $3,050.
14 "(IV) REDUCTION OF CIVIL
15 MONEY PENALTIES IN CERTAIN CIR-
16 CUMSTANCES.—Subject to subclauses
17 (V) and (VI), in the case where a fa-
18 cility self-reports and promptly cor-
19 rects a deficiency for which a penalty
20 was imposed under this clause not
21 later than 10 calendar days after the
22 date of such imposition, the Secretary
23 may reduce the amount of the penalty
24 imposed by not more than 50 percent.

1 "(V) PROHIBITION ON REDUC-
2 TION FOR CERTAIN DEFICIENCIES.—
3 "(aa) REPEAT DEFI-
4 CIENCIES.—The Secretary may
5 not reduce under subclause (IV)
6 the amount of a penalty if the
7 deficiency is a repeat deficiency.
8 "(bb) CERTAIN OTHER DE-
9 FICIENCIES.—The Secretary may
10 not reduce under subclause (IV)
11 the amount of a penalty if the
12 penalty is imposed for a defi-
13 ciency described in subclause
14 (II)(aa) or (III)(aa) and the ac-
15 tual harm or widespread harm
16 immediately jeopardizes the
17 health or safety of a resident or
18 residents of the facility, or if the
19 penalty is imposed for a defi-
20 ciency described in subclause
21 (II)(bb).
22 "(VI) LIMITATION ON AGGRE-
23 GATE REDUCTIONS.—The aggregate
24 reduction in a penalty under sub-
25 clause (IV) may not exceed 35 percent

1 on the basis of self-reporting, on the
2 basis of a waiver or an appeal (as pro-
3 vided for under regulations under sec-
4 tion 488.436 of title 42, Code of Fed-
5 eral Regulations), or on the basis of
6 both.

7 "(VII) COLLECTION OF CIVIL
8 MONEY PENALTIES.—In the case of a
9 civil money penalty imposed under
10 this clause, the Secretary—

11 "(aa) subject to item (cc),
12 shall, not later than 30 days
13 after the date of imposition of
14 the penalty, provide the oppor-
15 tunity for the facility to partici-
16 pate in an independent informal
17 dispute resolution process which
18 generates a written record prior
19 to the collection of such penalty,
20 but such opportunity shall not af-
21 fect the responsibility of the
22 State survey agency for making
23 final recommendations for such
24 penalties;

1 “(bb) in the case where the
2 penalty is imposed for each day
3 of noncompliance, shall not im-
4 pose a penalty for any day during
5 the period beginning on the ini-
6 tial day of the imposition of the
7 penalty and ending on the day on
8 which the informal dispute reso-
9 lution process under item (aa) is
10 completed;
11 “(cc) may provide for the
12 collection of such civil money
13 penalty and the placement of
14 such amounts collected in an es-
15 crow account under the direction
16 of the Secretary on the earlier of
17 the date on which the informal
18 dispute resolution process under
19 item (aa) is completed or the
20 date that is 90 days after the
21 date of the imposition of the pen-
22 alty;
23 “(dd) may provide that such
24 amounts collected are kept in

1 such account pending the resolu-
2 tion of any subsequent appeals;
3 "(ee) in the case where the
4 facility successfully appeals the
5 penalty, may provide for the re-
6 turn of such amounts collected
7 (plus interest) to the facility; and
8 "(ff) in the case where all
9 such appeals are unsuccessful,
10 may provide that some portion of
11 such amounts collected may be
12 used to support activities that
13 benefit residents, including as-
14 sistance to support and protect
15 residents of a facility that closes
16 (voluntarily or involuntarily) or is
17 decertified (including offsetting
18 costs of relocating residents to
19 home and community-based set-
20 tings or another facility), projects
21 that support resident and family
22 councils and other consumer in-
23 volvement in assuring quality
24 care in facilities, and facility im-
25 provement initiatives approved by

1 the Secretary (including joint
2 training of facility staff and sur-
3 veyors, technical assistance for
4 facilities under quality assurance
5 programs, the appointment of
6 temporary management, and
7 other activities approved by the
8 Secretary).
9 "(VIII) PROCEDURE.—The pro-
10 visions of section 1128A (other than
11 subsections (a) and (b) and except to
12 the extent that such provisions require
13 a hearing prior to the imposition of a
14 civil money penalty) shall apply to a
15 civil money penalty under this clause
16 in the same manner as such provi-
17 sions apply to a penalty or proceeding
18 under section 1128A(a).".
19 (2) CONFORMING AMENDMENT.—The second
20 sentence of section 1819(h)(5) of the Social Security
21 Act (42 U.S.C. 1395i–3(h)(5)) is amended by insert-
22 ing "(ii),"after "(i),".
23 (b) NURSING FACILITIES.—
24 (1) PENALTIES IMPOSED BY THE STATE.—

1 (A) IN GENERAL.—Section 1919(h)(2) of
2 the Social Security Act (42 U.S.C. 1396r(h)(2))
3 is amended—
4 (i) in subparagraph (A)(ii), by strik-
5 ing the first sentence and inserting the fol-
6 lowing: "A civil money penalty in accord-
7 ance with subparagraph (G)."; and
8 (ii) by adding at the end the following
9 new subparagraph:
10 "(G) CIVIL MONEY PENALTIES.—
11 "(i) IN GENERAL.—The State may
12 impose a civil money penalty under sub-
13 paragraph (A)(ii) in the applicable per in-
14 stance or per day amount (as defined in
15 subclause (II) and (III)) for each day or
16 instance, respectively, of noncompliance (as
17 determined appropriate by the Secretary).
18 "(ii) APPLICABLE PER INSTANCE
19 AMOUNT.—In this subparagraph, the term
20 'applicable per instance amount' means—
21 "(I) in the case where the defi-
22 ciency is found to be a direct proxi-
23 mate cause of death of a resident of
24 the facility, an amount not to exceed
25 $100,000.

1 "(II) in each case of a deficiency
2 where the facility is cited for actual
3 harm or immediate jeopardy, an
4 amount not less than $3,050 and not
5 more than $25,000; and

6 "(III) in each case of any other
7 deficiency, an amount not less than
8 $250 and not to exceed $3050.

9 "(iii) APPLICABLE PER DAY
10 AMOUNT.—In this subparagraph, the term
11 'applicable per day amount' means—

12 "(I) in each case of a deficiency
13 where the facility is cited for actual
14 harm or immediate jeopardy, an
15 amount not less than $3,050 and not
16 more than $25,000 and

17 "(II) in each case of any other
18 deficiency, an amount not less than
19 $250 and not to exceed $3,050.

20 "(iv) REDUCTION OF CIVIL MONEY
21 PENALTIES IN CERTAIN CIR-
22 CUMSTANCES.—Subject to clauses (v) and
23 (vi), in the case where a facility self-re-
24 ports and promptly corrects a deficiency
25 for which a penalty was imposed under

1 subparagraph (A)(ii) not later than 10 cal-
2 endar days after the date of such imposi-
3 tion, the State may reduce the amount of
4 the penalty imposed by not more than 50
5 percent.
6 "(v) PROHIBITION ON REDUCTION
7 FOR CERTAIN DEFICIENCIES.—
8 "(I) REPEAT DEFICIENCIES.—
9 The State may not reduce under
10 clause (iv) the amount of a penalty if
11 the State had reduced a penalty im-
12 posed on the facility in the preceding
13 year under such clause with respect to
14 a repeat deficiency.
15 "(II) CERTAIN OTHER DEFI-
16 CIENCIES.—The State may not reduce
17 under clause (iv) the amount of a pen-
18 alty if the penalty is imposed for a de-
19 ficiency described in clause (ii)(II) or
20 (iii)(I) and the actual harm or wide-
21 spread harm that immediately jeop-
22 ardizes the health or safety of a resi-
23 dent or residents of the facility, or if
24 the penalty is imposed for a deficiency
25 described in clause (ii)(I).

1 "(III) LIMITATION ON AGGRE-
2 GATE REDUCTIONS.—The aggregate
3 reduction in a penalty under clause
4 (iv) may not exceed 35 percent on the
5 basis of self-reporting, on the basis of
6 a waiver or an appeal (as provided for
7 under regulations under section
8 488.436 of title 42, Code of Federal
9 Regulations), or on the basis of both.
10 "(iv) COLLECTION OF CIVIL MONEY
11 PENALTIES.—In the case of a civil money
12 penalty imposed under subparagraph
13 (A)(ii), the State—
14 "(I) subject to subclause (III),
15 shall, not later than 30 days after the
16 date of imposition of the penalty, pro-
17 vide the opportunity for the facility to
18 participate in an independent informal
19 dispute resolution process which gen-
20 erates a written record prior to the
21 collection of such penalty, but such
22 opportunity shall not affect the re-
23 sponsibility of the State survey agency
24 for making final recommendations for
25 such penalties;

1 "(II) in the case where the pen-
2 alty is imposed for each day of non-
3 compliance, shall not impose a penalty
4 for any day during the period begin-
5 ning on the initial day of the imposi-
6 tion of the penalty and ending on the
7 day on which the informal dispute res-
8 olution process under subclause (I) is
9 completed;

10 "(III) may provide for the collec-
11 tion of such civil money penalty and
12 the placement of such amounts col-
13 lected in an escrow account under the
14 direction of the State on the earlier of
15 the date on which the informal dis-
16 pute resolution process under sub-
17 clause (I) is completed or the date
18 that is 90 days after the date of the
19 imposition of the penalty;

20 "(IV) may provide that such
21 amounts collected are kept in such ac-
22 count pending the resolution of any
23 subsequent appeals;

24 "(V) in the case where the facil-
25 ity successfully appeals the penalty,

1 may provide for the return of such
2 amounts collected (plus interest) to
3 the facility; and
4 "(VI) in the case where all such
5 appeals are unsuccessful, may provide
6 that such funds collected shall be used
7 for the purposes described in the sec-
8 ond sentence of subparagraph
9 (A)(ii).".
10 (B) CONFORMING AMENDMENT.—The sec-
11 ond sentence of section 1919(h)(2)(A)(ii) of the
12 Social Security Act (42 U.S.C.
13 1396r(h)(2)(A)(ii)) is amended by inserting be-
14 fore the period at the end the following: ", and
15 some portion of such funds may be used to sup-
16 port activities that benefit residents, including
17 assistance to support and protect residents of a
18 facility that closes (voluntarily or involuntarily)
19 or is decertified (including offsetting costs of re-
20 locating residents to home and community-
21 based settings or another facility), projects that
22 support resident and family councils and other
23 consumer involvement in assuring quality care
24 in facilities, and facility improvement initiatives
25 approved by the Secretary (including joint

1 training of facility staff and surveyors, pro-
2 viding technical assistance to facilities under
3 quality assurance programs, the appointment of
4 temporary management, and other activities ap-
5 proved by the Secretary)''.
6 (2) PENALTIES IMPOSED BY THE SEC-
7 RETARY.—
8 (A) IN GENERAL.—Section
9 1919(h)(3)(C)(ii) of the Social Security Act (42
10 U.S.C. 1396r(h)(3)(C)) is amended to read as
11 follows:
12 ''(ii) AUTHORITY WITH RESPECT TO
13 CIVIL MONEY PENALTIES.—
14 ''(I) AMOUNT.—Subject to sub-
15 clause (II), the Secretary may impose
16 a civil money penalty in an amount
17 not to exceed $10,000 for each day or
18 each instance of noncompliance (as
19 determined appropriate by the Sec-
20 retary).
21 ''(II) REDUCTION OF CIVIL
22 MONEY PENALTIES IN CERTAIN CIR-
23 CUMSTANCES.—Subject to subclause
24 (III), in the case where a facility self-
25 reports and promptly corrects a defi-

1 ciency for which a penalty was im-
2 posed under this clause not later than
3 10 calendar days after the date of
4 such imposition, the Secretary may
5 reduce the amount of the penalty im-
6 posed by not more than 50 percent.

7 "(III) PROHIBITION ON REDUC-
8 TION FOR REPEAT DEFICIENCIES.—
9 The Secretary may not reduce the
10 amount of a penalty under subclause
11 (II) if the Secretary had reduced a
12 penalty imposed on the facility in the
13 preceding year under such subclause
14 with respect to a repeat deficiency.

15 "(IV) COLLECTION OF CIVIL
16 MONEY PENALTIES.—In the case of a
17 civil money penalty imposed under
18 this clause, the Secretary—

19 "(aa) subject to item (bb),
20 shall, not later than 30 days
21 after the date of imposition of
22 the penalty, provide the oppor-
23 tunity for the facility to partici-
24 pate in an independent informal
25 dispute resolution process which

1 generates a written record prior
2 to the collection of such penalty;
3 "(bb) in the case where the
4 penalty is imposed for each day
5 of noncompliance, shall not im-
6 pose a penalty for any day during
7 the period beginning on the ini-
8 tial day of the imposition of the
9 penalty and ending on the day on
10 which the informal dispute reso-
11 lution process under item (aa) is
12 completed;
13 "(cc) may provide for the
14 collection of such civil money
15 penalty and the placement of
16 such amounts collected in an es-
17 crow account under the direction
18 of the Secretary on the earlier of
19 the date on which the informal
20 dispute resolution process under
21 item (aa) is completed or the
22 date that is 90 days after the
23 date of the imposition of the pen-
24 alty;

1 “(dd) may provide that such
2 amounts collected are kept in
3 such account pending the resolu-
4 tion of any subsequent appeals;
5 “(ee) in the case where the
6 facility successfully appeals the
7 penalty, may provide for the re-
8 turn of such amounts collected
9 (plus interest) to the facility; and
10 “(ff) in the case where all
11 such appeals are unsuccessful,
12 may provide that some portion of
13 such amounts collected may be
14 used to support activities that
15 benefit residents, including as-
16 sistance to support and protect
17 residents of a facility that closes
18 (voluntarily or involuntarily) or is
19 decertified (including offsetting
20 costs of relocating residents to
21 home and community-based set-
22 tings or another facility), projects
23 that support resident and family
24 councils and other consumer in-
25 volvement in assuring quality

1 care in facilities, and facility im-
2 provement initiatives approved by
3 the Secretary (including joint
4 training of facility staff and sur-
5 veyors, technical assistance for
6 facilities under quality assurance
7 programs, the appointment of
8 temporary management, and
9 other activities approved by the
10 Secretary).
11 ''(V) PROCEDURE.—The provi-
12 sions of section 1128A (other than
13 subsections (a) and (b) and except to
14 the extent that such provisions require
15 a hearing prior to the imposition of a
16 civil money penalty) shall apply to a
17 civil money penalty under this clause
18 in the same manner as such provi-
19 sions apply to a penalty or proceeding
20 under section 1128A(a).''.
21 (B) CONFORMING AMENDMENT.—Section
22 1919(h)(8) of the Social Security Act (42
23 U.S.C. 1396r(h)(5)(8)) is amended by inserting
24 ''and in paragraph (3)(C)(ii)'' after ''paragraph
25 (2)(A)''.

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

4 **SEC. 1422. NATIONAL INDEPENDENT MONITOR PILOT PRO-**
5 **GRAM.**

6 (a) ESTABLISHMENT.—
7 (1) IN GENERAL.—The Secretary, in consulta-
8 tion with the Inspector General of the Department
9 of Health and Human Services, shall establish a
10 pilot program (in this section referred to as the
11 ''pilot program'') to develop, test, and implement use
12 of an independent monitor to oversee interstate and
13 large intrastate chains of skilled nursing facilities
14 and nursing facilities.
15 (2) SELECTION.—The Secretary shall select
16 chains of skilled nursing facilities and nursing facili-
17 ties described in paragraph (1) to participate in the
18 pilot program from among those chains that submit
19 an application to the Secretary at such time, in such
20 manner, and containing such information as the Sec-
21 retary may require.
22 (3) DURATION.—The Secretary shall conduct
23 the pilot program for a two-year period.

1 (4) IMPLEMENTATION.—The Secretary shall
2 implement the pilot program not later than one year
3 after the date of the enactment of this Act.
4 (b) REQUIREMENTS.—The Secretary shall evaluate
5 chains selected to participate in the pilot program based
6 on criteria selected by the Secretary, including where evi-
7 dence suggests that one or more facilities of the chain are
8 experiencing serious safety and quality of care problems.
9 Such criteria may include the evaluation of a chain that
10 includes one or more facilities participating in the ''Special
11 Focus Facility'' program (or a successor program) or one
12 or more facilities with a record of repeated serious safety
13 and quality of care deficiencies.
14 (c) RESPONSIBILITIES OF THE INDEPENDENT MON-
15 ITOR.—An independent monitor that enters into a con-
16 tract with the Secretary to participate in the conduct of
17 such program shall—
18 (1) conduct periodic reviews and prepare root-
19 cause quality and deficiency analyses of a chain to
20 assess if facilities of the chain are in compliance
21 with State and Federal laws and regulations applica-
22 ble to the facilities;
23 (2) undertake sustained oversight of the chain,
24 whether publicly or privately held, to involve the
25 owners of the chain and the principal business part-

1 ners of such owners in facilitating compliance by fa-
2 cilities of the chain with State and Federal laws and
3 regulations applicable to the facilities;
4 (3) analyze the management structure, distribu-
5 tion of expenditures, and nurse staffing levels of fa-
6 cilities of the chain in relation to resident census,
7 staff turnover rates, and tenure;
8 (4) report findings and recommendations with
9 respect to such reviews, analyses, and oversight to
10 the chain and facilities of the chain, to the Secretary
11 and to relevant States; and
12 (5) publish the results of such reviews, anal-
13 yses, and oversight.
14 (d) IMPLEMENTATION OF RECOMMENDATIONS.—
15 (1) RECEIPT OF FINDING BY CHAIN.—Not later
16 than 10 days after receipt of a finding of an inde-
17 pendent monitor under subsection (c)(4), a chain
18 participating in the pilot program shall submit to
19 the independent monitor a report—
20 (A) outlining corrective actions the chain
21 will take to implement the recommendations in
22 such report; or
23 (B) indicating that the chain will not im-
24 plement such recommendations and why it will
25 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.

1 (2) NURSING FACILITY.—The term ''nursing
2 facility'' has the meaning given such term in section
3 1919(a) of the Social Security Act (42 U.S.C.
4 1396r(a)).
5 (3) SECRETARY.—The term ''Secretary'' means
6 the Secretary of Health and Human Services, acting
7 through the Assistant Secretary for Planning and
8 Evaluation.
9 (4) SKILLED NURSING FACILITY.—The term
10 ''skilled nursing facility'' has the meaning given such
11 term in section 1819(a) of the Social Security Act
12 (42 U.S.C. 1395(a)).
13 (i) EVALUATION AND REPORT.—
14 (1) EVALUATION.—The Inspector General of
15 the Department of Health and Human Services shall
16 evaluate the pilot program. Such evaluation shall—
17 (A) determine whether the independent
18 monitor program should be established on a
19 permanent basis; and
20 (B) if the Inspector General determines
21 that the independent monitor program should
22 be established on a permanent basis, rec-
23 ommend appropriate procedures and mecha-
24 nisms for such establishment.

1 (2) REPORT.—Not later than 180 days after
2 the completion of the pilot program, the Inspector
3 General shall submit to Congress and the Secretary
4 a report containing the results of the evaluation con-
5 ducted under paragraph (1), together with rec-
6 ommendations for such legislation and administra-
7 tive action as the Inspector General determines ap-
8 propriate.

9 **SEC. 1423. NOTIFICATION OF FACILITY CLOSURE.**

10 (a) SKILLED NURSING FACILITIES.—
11 (1) IN GENERAL.—Section 1819(c) of the So-
12 cial Security Act (42 U.S.C. 1395i–3(c)) is amended
13 by adding at the end the following new paragraph:
14 ‘‘(7) NOTIFICATION OF FACILITY CLOSURE.—
15 ‘‘(A) IN GENERAL.—Any individual who is
16 the administrator of a skilled nursing facility
17 must—
18 ‘‘(i) submit to the Secretary, the State
19 long-term care ombudsman, residents of
20 the facility, and the legal representatives of
21 such residents or other responsible parties,
22 written notification of an impending clo-
23 sure—

1 "(I) subject to subclause (II), not
2 later than the date that is 60 days
3 prior to the date of such closure; and
4 "(II) in the case of a facility
5 where the Secretary terminates the fa-
6 cility's participation under this title,
7 not later than the date that the Sec-
8 retary determines appropriate;
9 "(ii) ensure that the facility does not
10 admit any new residents on or after the
11 date on which such written notification is
12 submitted; and
13 "(iii) include in the notice a plan for
14 the transfer and adequate relocation of the
15 residents of the facility by a specified date
16 prior to closure that has been approved by
17 the State, including assurances that the
18 residents will be transferred to the most
19 appropriate facility or other setting in
20 terms of quality, services, and location,
21 taking into consideration the needs and
22 best interests of each resident.
23 "(B) RELOCATION.—
24 "(i) IN GENERAL.—The State shall
25 ensure that, before a facility closes, all

1 residents of the facility have been success-
2 fully relocated to another facility or an al-
3 ternative home and community-based set-
4 ting.

5 "(ii) CONTINUATION OF PAYMENTS
6 UNTIL RESIDENTS RELOCATED.—The Sec-
7 retary may, as the Secretary determines
8 appropriate, continue to make payments
9 under this title with respect to residents of
10 a facility that has submitted a notification
11 under subparagraph (A) during the period
12 beginning on the date such notification is
13 submitted and ending on the date on which
14 the resident is successfully relocated.".

15 (2) CONFORMING AMENDMENTS.—Section
16 1819(h)(4) of the Social Security Act (42 U.S.C.
17 1395i–3(h)(4)) is amended—

18 (A) in the first sentence, by striking "the
19 Secretary shall terminate" and inserting "the
20 Secretary, subject to subsection (c)(7), shall
21 terminate"; and

22 (B) in the second sentence, by striking
23 "subsection (c)(2)" and inserting "paragraphs
24 (2) and (7) of subsection (c)".

25 (b) NURSING FACILITIES.—

1 (1) IN GENERAL.—Section 1919(c) of the So-
2 cial Security Act (42 U.S.C. 1396r(c)) is amended
3 by adding at the end the following new paragraph:
4 ''(9) NOTIFICATION OF FACILITY CLOSURE.—
5 ''(A) IN GENERAL.—Any individual who is
6 an administrator of a nursing facility must—
7 ''(i) submit to the Secretary, the State
8 long-term care ombudsman, residents of
9 the facility, and the legal representatives of
10 such residents or other responsible parties,
11 written notification of an impending clo-
12 sure—
13 ''(I) subject to subclause (II), not
14 later than the date that is 60 days
15 prior to the date of such closure; and
16 ''(II) in the case of a facility
17 where the Secretary terminates the fa-
18 cility's participation under this title,
19 not later than the date that the Sec-
20 retary determines appropriate;
21 ''(ii) ensure that the facility does not
22 admit any new residents on or after the
23 date on which such written notification is
24 submitted; and

1 "(iii) include in the notice a plan for
2 the transfer and adequate relocation of the
3 residents of the facility by a specified date
4 prior to closure that has been approved by
5 the State, including assurances that the
6 residents will be transferred to the most
7 appropriate facility or other setting in
8 terms of quality, services, and location,
9 taking into consideration the needs and
10 best interests of each resident.

11 "(B) RELOCATION.—

12 "(i) IN GENERAL.—The State shall
13 ensure that, before a facility closes, all
14 residents of the facility have been success-
15 fully relocated to another facility or an al-
16 ternative home and community-based set-
17 ting.

18 "(ii) CONTINUATION OF PAYMENTS
19 UNTIL RESIDENTS RELOCATED.—The Sec-
20 retary may, as the Secretary determines
21 appropriate, continue to make payments
22 under this title with respect to residents of
23 a facility that has submitted a notification
24 under subparagraph (A) during the period
25 beginning on the date such notification is

1 submitted and ending on the date on which
2 the resident is successfully relocated.''.
3 (c) EFFECTIVE DATE.—The amendments made by
4 this section shall take effect 1 year after the date of the
5 enactment of this Act.

6 **PART 3—IMPROVING STAFF TRAINING**

7 **SEC. 1431. DEMENTIA AND ABUSE PREVENTION TRAINING.**

8 (a) SKILLED NURSING FACILITIES.—Section
9 1819(f)(2)(A)(i)(I) of the Social Security Act (42 U.S.C.
10 1395i–3(f)(2)(A)(i)(I)) is amended by inserting ''(includ-
11 ing, in the case of initial training and, if the Secretary
12 determines appropriate, in the case of ongoing training,
13 dementia management training and resident abuse preven-
14 tion training)'' after ''curriculum''.
15 (b) NURSING FACILITIES.—Section
16 1919(f)(2)(A)(i)(I) of the Social Security Act (42 U.S.C.
17 1396r(f)(2)(A)(i)(I)) is amended by inserting ''(including,
18 in the case of initial training and, if the Secretary deter-
19 mines appropriate, in the case of ongoing training, demen-
20 tia management training and resident abuse prevention
21 training)'' after ''curriculum''.
22 (c) EFFECTIVE DATE.—The amendments made by
23 this section shall take effect 1 year after the date of the
24 enactment of this Act.

1 **SEC. 1432. STUDY AND REPORT ON TRAINING REQUIRED**
2 **FOR CERTIFIED NURSE AIDES AND SUPER-**
3 **VISORY STAFF.**

4 (a) STUDY.—

5 (1) IN GENERAL.—The Secretary shall conduct
6 a study on the content of training for certified nurse
7 aides and supervisory staff of skilled nursing facili-
8 ties and nursing facilities. The study shall include an
9 analysis of the following:

10 (A) Whether the number of initial training
11 hours for certified nurse aides required under
12 sections 1819(f)(2)(A)(i)(II) and
13 1919(f)(2)(A)(i)(II) of the Social Security Act
14 (42 U.S.C. 1395i–3(f)(2)(A)(i)(II);
15 1396r(f)(2)(A)(i)(II)) should be increased from
16 75 and, if so, what the required number of ini-
17 tial training hours should be, including any rec-
18 ommendations for the content of such training
19 (including training related to dementia).

20 (B) Whether requirements for ongoing
21 training under such sections
22 1819(f)(2)(A)(i)(II) and 1919(f)(2)(A)(i)(II)
23 should be increased from 12 hours per year, in-
24 cluding any recommendations for the content of
25 such training.

1 (2) CONSULTATION.—In conducting the anal-
2 ysis under paragraph (1)(A), the Secretary shall
3 consult with States that, as of the date of the enact-
4 ment of this Act, require more than 75 hours of
5 training for certified nurse aides.
6 (3) DEFINITIONS.—In this section:
7 (A) NURSING FACILITY.—The term ''nurs-
8 ing facility'' has the meaning given such term
9 in section 1919(a) of the Social Security Act
10 (42 U.S.C. 1396r(a)).
11 (B) SECRETARY.—The term ''Secretary''
12 means the Secretary of Health and Human
13 Services, acting through the Assistant Secretary
14 for Planning and Evaluation.
15 (C) SKILLED NURSING FACILITY.—The
16 term ''skilled nursing facility'' has the meaning
17 given such term in section 1819(a) of the Social
18 Security Act (42 U.S.C. 1395(a)).
19 (b) REPORT.—Not later than 2 years after the date
20 of the enactment of this Act, the Secretary shall submit
21 to Congress a report containing the results of the study
22 conducted under subsection (a), together with rec-
23 ommendations for such legislation and administrative ac-
24 tion 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

1 to patients with prevalent, high-cost chronic dis-
2 eases;
3 "(2) have the greatest potential to decrease
4 morbidity and mortality in this country, including
5 those that are designed to eliminate harm to pa-
6 tients;
7 "(3) have the greatest potential for improving
8 the performance, affordability, and patient-
9 centeredness of health care, including those due to
10 variations in care;
11 "(4) address health disparities across groups
12 and areas; and
13 "(5) have the potential for rapid improvement
14 due to existing evidence, standards of care or other
15 reasons.
16 "(d) DEFINITIONS.—In this part:
17 "(1) CONSENSUS-BASED ENTITY.—The term
18 'consensus-based entity' means an entity with a con-
19 tract with the Secretary under section 1890.
20 "(2) QUALITY MEASURE.—The term 'quality
21 measure' means a national consensus standard for
22 measuring the performance and improvement of pop-
23 ulation health, or of institutional providers of serv-
24 ices, physicians, and other health care practitioners
25 in the delivery of health care services.

1 "(e) FUNDING.—

2 "(1) IN GENERAL.—The Secretary shall provide
3 for the transfer, from the Federal Hospital Insur-
4 ance Trust Fund under section 1817 and the Fed-
5 eral Supplementary Medical Insurance Trust Fund
6 under section 1841 (in such proportion as the Sec-
7 retary determines appropriate), of $2,000,000, for
8 the activities under this section for each of the fiscal
9 years 2010 through 2014.

10 "(2) AUTHORIZATION OF APPROPRIATIONS.—
11 For purposes of carrying out the provisions of this
12 section, in addition to funds otherwise available, out
13 of any funds in the Treasury not otherwise appro-
14 priated, there are appropriated to the Secretary of
15 Health and Human Services $2,000,000 for each of
16 the fiscal years 2010 through 2014.".

17 **SEC. 1442. DEVELOPMENT OF NEW QUALITY MEASURES;**
18 **GAO EVALUATION OF DATA COLLECTION**
19 **PROCESS FOR QUALITY MEASUREMENT.**

20 Part E of title XI of the Social Security Act, as added
21 by section 1441, is amended by adding at the end the fol-
22 lowing new sections:

23 **"SEC. 1192. DEVELOPMENT OF NEW QUALITY MEASURES.**

24 "(a) AGREEMENTS WITH QUALIFIED ENTITIES.—

1 "(1) IN GENERAL.—The Secretary shall enter
2 into agreements with qualified entities to develop
3 quality measures for the delivery of health care serv-
4 ices in the United States.
5 "(2) FORM OF AGREEMENTS.—The Secretary
6 may carry out paragraph (1) by contract, grant, or
7 otherwise.
8 "(3) RECOMMENDATIONS OF CONSENSUS-
9 BASED ENTITY.—In carrying out this section, the
10 Secretary shall—
11 "(A) seek public input; and
12 "(B) take into consideration recommenda-
13 tions of the consensus-based entity with a con-
14 tract with the Secretary under section 1890(a).
15 "(b) DETERMINATION OF AREAS WHERE QUALITY
16 MEASURES ARE REQUIRED.—Consistent with the na-
17 tional priorities established under this part and with the
18 programs administered by the Centers for Medicare &
19 Medicaid Services and in consultation with other relevant
20 Federal agencies, the Secretary shall determine areas in
21 which quality measures for assessing health care services
22 in the United States are needed.
23 "(c) DEVELOPMENT OF QUALITY MEASURES.—
24 "(1) PATIENT-CENTERED AND POPULATION-
25 BASED MEASURES.—Quality measures developed

1 under agreements under subsection (a) shall be de-
2 signed—
3 ‘‘(A) to assess outcomes and functional
4 status of patients;
5 ‘‘(B) to assess the continuity and coordina-
6 tion of care and care transitions for patients
7 across providers and health care settings, in-
8 cluding end of life care;
9 ‘‘(C) to assess patient experience and pa-
10 tient engagement;
11 ‘‘(D) to assess the safety, effectiveness,
12 and timeliness of care;
13 ‘‘(E) to assess health disparities including
14 those associated with individual race, ethnicity,
15 age, gender, place of residence or language;
16 ‘‘(F) to assess the efficiency and resource
17 use in the provision of care;
18 ‘‘(G) to the extent feasible, to be collected
19 as part of health information technologies sup-
20 porting better delivery of health care services;
21 ‘‘(H) to be available free of charge to users
22 for the use of such measures; and
23 ‘‘(I) to assess delivery of health care serv-
24 ices to individuals regardless of age.

1 "(2) AVAILABILITY OF MEASURES.—The Sec-
2 retary shall make quality measures developed under
3 this section available to the public.
4 "(3) TESTING OF PROPOSED MEASURES.—The
5 Secretary may use amounts made available under
6 subsection (f) to fund the testing of proposed quality
7 measures by qualified entities. Testing funded under
8 this paragraph shall include testing of the feasibility
9 and usability of proposed measures.
10 "(4) UPDATING OF ENDORSED MEASURES.—
11 The Secretary may use amounts made available
12 under subsection (f) to fund the updating (and test-
13 ing, if applicable) by consensus-based entities of
14 quality measures that have been previously endorsed
15 by such an entity as new evidence is developed, in
16 a manner consistent with section 1890(b)(3).
17 "(d) QUALIFIED ENTITIES.—Before entering into
18 agreements with a qualified entity, the Secretary shall en-
19 sure that the entity is a public, nonprofit or academic in-
20 stitution with technical expertise in the area of health
21 quality measurement.
22 "(e) APPLICATION FOR GRANT.—A grant may be
23 made under this section only if an application for the
24 grant is submitted to the Secretary and the application
25 is in such form, is made in such manner, and contains

1 such agreements, assurances, and information as the Sec-
2 retary determines to be necessary to carry out this section.
3 ‘‘(f) FUNDING.—
4 ‘‘(1) IN GENERAL.—The Secretary shall provide
5 for the transfer, from the Federal Hospital Insur-
6 ance Trust Fund under section 1817 and the Fed-
7 eral Supplementary Medical Insurance Trust Fund
8 under section 1841 (in such proportion as the Sec-
9 retary determines appropriate), of $25,000,000, to
10 the Secretary for purposes of carrying out this sec-
11 tion for each of the fiscal years 2010 through 2014.
12 ‘‘(2) AUTHORIZATION OF APPROPRIATIONS.—
13 For purposes of carrying out the provisions of this
14 section, in addition to funds otherwise available, out
15 of any funds in the Treasury not otherwise appro-
16 priated, there are appropriated to the Secretary of
17 Health and Human Services $25,000,000 for each
18 of the fiscal years 2010 through 2014.

19 **‘‘SEC. 1193. GAO EVALUATION OF DATA COLLECTION PROC-**
20 **ESS FOR QUALITY MEASUREMENT.**

21 ‘‘(a) GAO EVALUATIONS.—The Comptroller General
22 of the United States shall conduct periodic evaluations of
23 the implementation of the data collection processes for
24 quality measures used by the Secretary.

1 "(b) CONSIDERATIONS.—In carrying out the evalua-
2 tion under subsection (a), the Comptroller General shall
3 determine—
4 "(1) whether the system for the collection of
5 data for quality measures provides for validation of
6 data as relevant and scientifically credible;
7 "(2) whether data collection efforts under the
8 system use the most efficient and cost-effective
9 means in a manner that minimizes administrative
10 burden on persons required to collect data and that
11 adequately protects the privacy of patients' personal
12 health information and provides data security;
13 "(3) whether standards under the system pro-
14 vide for an appropriate opportunity for physicians
15 and other clinicians and institutional providers of
16 services to review and correct findings; and
17 "(4) the extent to which quality measures are
18 consistent with section 1192(c)(1) or result in direct
19 or indirect costs to users of such measures.
20 "(c) REPORT.—The Comptroller General shall sub-
21 mit reports to Congress and to the Secretary containing
22 a description of the findings and conclusions of the results
23 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.

1 "(3) MULTI-STAKEHOLDER INPUT.—Not later
2 than February 1 of each year (beginning with
3 2011), the consensus-based entity described in para-
4 graph (2) shall transmit to the Secretary the rec-
5 ommendations of multi-stakeholder groups provided
6 under paragraph (2). Such recommendations shall
7 be included in the transmissions the consensus-based
8 entity makes to the Secretary under the contract
9 provided for under section 1890.
10 "(4) REQUIREMENT FOR TRANSPARENCY IN
11 PROCESS.—
12 "(A) IN GENERAL.—In convening multi-
13 stakeholder groups under paragraph (2) with
14 respect to the selection of quality measures, the
15 consensus-based entity described in such para-
16 graph shall provide for an open and transparent
17 process for the activities conducted pursuant to
18 such convening.
19 "(B) SELECTION OF ORGANIZATIONS PAR-
20 TICIPATING IN MULTI-STAKEHOLDER
21 GROUPS.—The process under paragraph (2)
22 shall ensure that the selection of representatives
23 of multi-stakeholder groups includes provision
24 for public nominations for, and the opportunity
25 for public comment on, such selection.

1 "(5) USE OF INPUT.—The respective proposed
2 rule shall contain a summary of the recommenda-
3 tions made by the multi-stakeholder groups under
4 paragraph (2), as well as other comments received
5 regarding the proposed measures, and the extent to
6 which such proposed rule follows such recommenda-
7 tions and the rationale for not following such rec-
8 ommendations.
9 "(6) MULTI-STAKEHOLDER GROUPS.—For pur-
10 poses of this subsection, the term 'multi-stakeholder
11 groups' means, with respect to a quality measure, a
12 voluntary collaborative of organizations representing
13 persons interested in or affected by the use of such
14 quality measure, such as the following:
15 "(A) Hospitals and other institutional pro-
16 viders.
17 "(B) Physicians.
18 "(C) Health care quality alliances.
19 "(D) Nurses and other health care practi-
20 tioners.
21 "(E) Health plans.
22 "(F) Patient advocates and consumer
23 groups.
24 "(G) Employers.

1 “(H) Public and private purchasers of
2 health care items and services.
3 “(I) Labor organizations.
4 “(J) Relevant departments or agencies of
5 the United States.
6 “(K) Biopharmaceutical companies and
7 manufacturers of medical devices.
8 “(L) Licensing, credentialing, and accred-
9 iting bodies.
10 “(7) FUNDING.—
11 “(A) IN GENERAL.—The Secretary shall
12 provide for the transfer, from the Federal Hos-
13 pital Insurance Trust Fund under section 1817
14 and the Federal Supplementary Medical Insur-
15 ance Trust Fund under section 1841 (in such
16 proportion as the Secretary determines appro-
17 priate), of $1,000,000, to the Secretary for pur-
18 poses of carrying out this subsection for each of
19 the fiscal years 2010 through 2014.
20 “(B) AUTHORIZATION OF APPROPRIA-
21 TIONS.—For purposes of carrying out the provi-
22 sions of this subsection, in addition to funds
23 otherwise available, out of any funds in the
24 Treasury not otherwise appropriated, there are
25 appropriated to the Secretary of Health and

1 Human Services $1,000,000 for each of the fis-
2 cal years 2010 through 2014.''.

3 **SEC. 1444. APPLICATION OF QUALITY MEASURES.**

4 (a) INPATIENT HOSPITAL SERVICES.—Section
5 1886(b)(3)(B) of such Act (42 U.S.C. 1395ww(b)(3)(B))
6 is amended by adding at the end the following new clause:
7 ''(x)(I) Subject to subclause (II), for purposes of re-
8 porting data on quality measures for inpatient hospital
9 services furnished during fiscal year 2012 and each subse-
10 quent fiscal year, the quality measures specified under
11 clause (viii) shall be measures selected by the Secretary
12 from measures that have been endorsed by the entity with
13 a contract with the Secretary under section 1890(a).

14 ''(II) In the case of a specified area or medical topic
15 determined appropriate by the Secretary for which a fea-
16 sible and practical quality measure has not been endorsed
17 by the entity with a contract under section 1890(a), the
18 Secretary may specify a measure that is not so endorsed
19 as long as due consideration is given to measures that
20 have been endorsed or adopted by a consensus organiza-
21 tion identified by the Secretary. The Secretary shall sub-
22 mit such a non-endorsed measure to the entity for consid-
23 eration for endorsement. If the entity considers but does
24 not endorse such a measure and if the Secretary does not
25 phase-out use of such measure, the Secretary shall include

1 the rationale for continued use of such a measure in rule-
2 making.''.
3 (b) OUTPATIENT HOSPITAL SERVICES.—Section
4 1833(t)(17) of such Act (42 U.S.C. 1395l(t)(17)) is
5 amended by adding at the end the following new subpara-
6 graph:
7 ''(F) USE OF ENDORSED QUALITY MEAS-
8 URES.—The provisions of clause (x) of section
9 1886(b)(3)(C) shall apply to quality measures
10 for covered OPD services under this paragraph
11 in the same manner as such provisions apply to
12 quality measures for inpatient hospital serv-
13 ices.''.
14 (c) PHYSICIANS' SERVICES.—Section
15 1848(k)(2)(C)(ii) of such Act (42 U.S.C. 1395w-
16 4(k)(2)(C)(ii)) is amended by adding at the end the fol-
17 lowing: ''The Secretary shall submit such a non-endorsed
18 measure to the entity for consideration for endorsement.
19 If the entity considers but does not endorse such a meas-
20 ure and if the Secretary does not phase-out use of such
21 measure, the Secretary shall include the rationale for con-
22 tinued use of such a measure in rulemaking.''.''.
23 (d) RENAL DIALYSIS SERVICES.—Section
24 1881(h)(2)(B)(ii) of such Act (42 U.S.C.
25 1395rr(h)(2)(B)(ii)) is amended by adding at the end the

1 following: ''The Secretary shall submit such a non-en-
2 dorsed measure to the entity for consideration for endorse-
3 ment. If the entity considers but does not endorse such
4 a measure and if the Secretary does not phase-out use
5 of such measure, the Secretary shall include the rationale
6 for continued use of such a measure in rulemaking.''.

7 (e) ENDORSEMENT OF STANDARDS.—Section
8 1890(b)(2) of the Social Security Act (42 U.S.C.
9 1395aaa(b)(2)) is amended by adding after and below sub-
10 paragraph (B) the following:

11 '' 'If the entity does not endorse a measure, such en-
12 tity shall explain the reasons and provide sugges-
13 tions about changes to such measure that might
14 make it a potentially endorsable measure.' ''.

15 (f) EFFECTIVE DATE.—Except as otherwise pro-
16 vided, the amendments made by this section shall apply
17 to quality measures applied for payment years beginning
18 with 2012 or fiscal year 2012, as the case may be.

19 **SEC. 1445. CONSENSUS-BASED ENTITY FUNDING.**

20 Section 1890(d) of the Social Security Act (42 U.S.C.
21 1395aaa(d)) is amended by striking ''for each of fiscal
22 years 2009 through 2012'' and inserting ''for fiscal year
23 2009, and $12,000,000 for each of the fiscal years 2010
24 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-

1 nually thereafter, each applicable manufacturer or
2 distributor that provides a payment or other transfer
3 of value to a covered recipient, or to an entity or in-
4 dividual at the request of or designated on behalf of
5 a covered recipient, shall submit to the Secretary, in
6 such electronic form as the Secretary shall require,
7 the following information with respect to the pre-
8 ceding calendar year:
9 "(A) With respect to the covered recipient,
10 the recipient's name, business address, physi-
11 cian specialty, and national provider identifier.
12 "(B) With respect to the payment or other
13 transfer of value, other than a drug sample—
14 "(i) its value and date;
15 "(ii) the name of the related drug, de-
16 vice, or supply, if available; and
17 "(iii) a description of its form, indi-
18 cated (as appropriate for all that apply)
19 as—
20 "(I) cash or a cash equivalent;
21 "(II) in-kind items or services;
22 "(III) stock, a stock option, or
23 any other ownership interest, divi-
24 dend, profit, or other return on invest-
25 ment; or

1 "(IV) any other form (as defined
2 by the Secretary).
3 "(C) With respect to a drug sample, the
4 name, number, date, and dosage units of the
5 sample.
6 "(2) AGGREGATE REPORTING.—Information
7 submitted by an applicable manufacturer or dis-
8 tributor under paragraph (1) shall include the ag-
9 gregate amount of all payments or other transfers of
10 value provided by the manufacturer or distributor to
11 covered recipients (and to entities or individuals at
12 the request of or designated on behalf of a covered
13 recipient) during the year involved, including all pay-
14 ments and transfers of value regardless of whether
15 such payments or transfer of value were individually
16 disclosed.
17 "(3) SPECIAL RULE FOR CERTAIN PAYMENTS
18 OR OTHER TRANSFERS OF VALUE.—In the case
19 where an applicable manufacturer or distributor pro-
20 vides a payment or other transfer of value to an en-
21 tity or individual at the request of or designated on
22 behalf of a covered recipient, the manufacturer or
23 distributor shall disclose that payment or other
24 transfer of value under the name of the covered re-
25 cipient.

1 "(4) DELAYED REPORTING FOR PAYMENTS
2 MADE PURSUANT TO PRODUCT DEVELOPMENT
3 AGREEMENTS.—In the case of a payment or other
4 transfer of value made to a covered recipient by an
5 applicable manufacturer or distributor pursuant to a
6 product development agreement for services fur-
7 nished in connection with the development of a new
8 drug, device, biological, or medical supply, the appli-
9 cable manufacturer or distributor may report the
10 value and recipient of such payment or other trans-
11 fer of value in the first reporting period under this
12 subsection in the next reporting deadline after the
13 earlier of the following:
14 "(A) The date of the approval or clearance
15 of the covered drug, device, biological, or med-
16 ical supply by the Food and Drug Administra-
17 tion.
18 "(B) Two calendar years after the date
19 such payment or other transfer of value was
20 made.
21 "(5) DELAYED REPORTING FOR PAYMENTS
22 MADE PURSUANT TO CLINICAL INVESTIGATIONS.—In
23 the case of a payment or other transfer of value
24 made to a covered recipient by an applicable manu-
25 facturer or distributor in connection with a clinical

1 investigation regarding a new drug, device, biologi-
2 cal, or medical supply, the applicable manufacturer
3 or distributor may report as required under this sec-
4 tion in the next reporting period under this sub-
5 section after the earlier of the following:

6 "(A) The date that the clinical investiga-
7 tion is registered on the website maintained by
8 the National Institutes of Health pursuant to
9 section 671 of the Food and Drug Administra-
10 tion Amendments Act of 2007.

11 "(B) Two calendar years after the date
12 such payment or other transfer of value was
13 made.

14 "(6) CONFIDENTIALITY.—Information de-
15 scribed in paragraph (4) or (5) shall be considered
16 confidential and shall not be subject to disclosure
17 under section 552 of title 5, United States Code, or
18 any other similar Federal, State, or local law, until
19 or after the date on which the information is made
20 available to the public under such paragraph.

21 "(b) REPORTING OF OWNERSHIP INTEREST BY PHY-
22 SICIANS IN HOSPITALS AND OTHER ENTITIES THAT BILL
23 MEDICARE.—Not later than March 31 of each year (be-
24 ginning with 2011), each hospital or other health care en-
25 tity (not including a Medicare Advantage organization)

1 that bills the Secretary under part A or part B of title
2 XVIII for services shall report on the ownership shares
3 (other than ownership shares described in section 1877(c))
4 of each physician who, directly or indirectly, owns an in-
5 terest in the entity. In this subsection, the term 'physician'
6 includes a physician's immediate family members (as de-
7 fined for purposes of section 1877(a)).

8 ''(c) PUBLIC AVAILABILITY.—

9 ''(1) IN GENERAL.—The Secretary shall estab-
10 lish procedures to ensure that, not later than Sep-
11 tember 30, 2011, and on June 30 of each year be-
12 ginning thereafter, the information submitted under
13 subsections (a) and (b), other than information re-
14 gard drug samples, with respect to the preceding
15 calendar year is made available through an Internet
16 website that—

17 ''(A) is searchable and is in a format that
18 is clear and understandable;

19 ''(B) contains information that is pre-
20 sented by the name of the applicable manufac-
21 turer or distributor, the name of the covered re-
22 cipient, the business address of the covered re-
23 cipient, the specialty (if applicable) of the cov-
24 ered recipient, the value of the payment or
25 other transfer of value, the date on which the

1 payment or other transfer of value was provided
2 to the covered recipient, the form of the pay-
3 ment or other transfer of value, indicated (as
4 appropriate) under subsection (a)(1)(B)(ii), the
5 nature of the payment or other transfer of
6 value, indicated (as appropriate) under sub-
7 section (a)(1)(B)(iii), and the name of the cov-
8 ered drug, device, biological, or medical supply,
9 as applicable;
10 ''(C) contains information that is able to
11 be easily aggregated and downloaded;
12 ''(D) contains a description of any enforce-
13 ment actions taken to carry out this section, in-
14 cluding any penalties imposed under subsection
15 (d), during the preceding year;
16 ''(E) contains background information on
17 industry-physician relationships;
18 ''(F) in the case of information submitted
19 with respect to a payment or other transfer of
20 value described in subsection (a)(5), lists such
21 information separately from the other informa-
22 tion submitted under subsection (a) and des-
23 ignates such separately listed information as
24 funding for clinical research;

1 "(G) contains any other information the
2 Secretary determines would be helpful to the
3 average consumer; and
4 "(H) provides the covered recipient an op-
5 portunity to submit corrections to the informa-
6 tion made available to the public with respect to
7 the covered recipient.
8 "(2) ACCURACY OF REPORTING.—The accuracy
9 of the information that is submitted under sub-
10 sections (a) and (b) and made available under para-
11 graph (1) shall be the responsibility of the applicable
12 manufacturer or distributor of a covered drug, de-
13 vice, biological, or medical supply reporting under
14 subsection (a) or hospital or other health care entity
15 reporting physician ownership under subsection (b).
16 The Secretary shall establish procedures to ensure
17 that the covered recipient is provided with an oppor-
18 tunity to submit corrections to the manufacturer,
19 distributor, hospital, or other entity reporting under
20 subsection (a) or (b) with regard to information
21 made public with respect to the covered recipient
22 and, under such procedures, the corrections shall be
23 transmitted to the Secretary.
24 "(3) SPECIAL RULE FOR DRUG SAMPLES.—In-
25 formation relating to drug samples provided under

1 subsection (a) shall not be made available to the
2 public by the Secretary but may be made available
3 outside the Department of Health and Human Serv-
4 ices by the Secretary for research or legitimate busi-
5 ness purposes pursuant to data use agreements.
6 "(4) SPECIAL RULE FOR NATIONAL PROVIDER
7 IDENTIFIERS.—Information relating to national pro-
8 vider identifiers provided under subsection (a) shall
9 not be made available to the public by the Secretary
10 but may be made available outside the Department
11 of Health and Human Services by the Secretary for
12 research or legitimate business purposes pursuant to
13 data use agreements.
14 "(d) PENALTIES FOR NONCOMPLIANCE.—
15 "(1) FAILURE TO REPORT.—
16 "(A) IN GENERAL.—Subject to subpara-
17 graph (B), except as provided in paragraph (2),
18 any applicable manufacturer or distributor that
19 fails to submit information required under sub-
20 section (a) in a timely manner in accordance
21 with regulations promulgated to carry out such
22 subsection, and any hospital or other entity that
23 fails to submit information required under sub-
24 section (b) in a timely manner in accordance
25 with regulations promulgated to carry out such

1 subsection shall be subject to a civil money pen-
2 alty of not less than $1,000, but not more than
3 $10,000, for each payment or other transfer of
4 value or ownership or investment interest not
5 reported as required under such subsection.
6 Such penalty shall be imposed and collected in
7 the same manner as civil money penalties under
8 subsection (a) of section 1128A are imposed
9 and collected under that section.

10 ''(B) LIMITATION.—The total amount of
11 civil money penalties imposed under subpara-
12 graph (A) with respect to each annual submis-
13 sion of information under subsection (a) by an
14 applicable manufacturer or distributor or other
15 entity shall not exceed $150,000.

16 ''(2) KNOWING FAILURE TO REPORT.—

17 ''(A) IN GENERAL.—Subject to subpara-
18 graph (B), any applicable manufacturer or dis-
19 tributor that knowingly fails to submit informa-
20 tion required under subsection (a) in a timely
21 manner in accordance with regulations promul-
22 gated to carry out such subsection and any hos-
23 pital or other entity that fails to submit infor-
24 mation required under subsection (b) in a time-
25 ly manner in accordance with regulations pro-

1 mulgated to carry out such subsection, shall be
2 subject to a civil money penalty of not less than
3 $10,000, but not more than $100,000, for each
4 payment or other transfer of value or ownership
5 or investment interest not reported as required
6 under such subsection. Such penalty shall be
7 imposed and collected in the same manner as
8 civil money penalties under subsection (a) of
9 section 1128A are imposed and collected under
10 that section.

11 "(B) LIMITATION.—The total amount of
12 civil money penalties imposed under subpara-
13 graph (A) with respect to each annual submis-
14 sion of information under subsection (a) or (b)
15 by an applicable manufacturer, distributor, or
16 entity shall not exceed $1,000,000, or, if great-
17 er, 0.1 percentage of the total annual revenues
18 of the manufacturer, distributor, or entity.

19 "(3) USE OF FUNDS.—Funds collected by the
20 Secretary as a result of the imposition of a civil
21 money penalty under this subsection shall be used to
22 carry out this section.

23 "(4) ENFORCEMENT THROUGH STATE ATTOR-
24 NEYS GENERAL.—The attorney general of a State,
25 after providing notice to the Secretary of an intent

1 to proceed under this paragraph in a specific case
2 and providing the Secretary with an opportunity to
3 bring an action under this subsection and the Sec-
4 retary declining such opportunity, may proceed
5 under this subsection against a manufacturer or dis-
6 tributor in the State.

7 "(e) ANNUAL REPORT TO CONGRESS.—Not later
8 than April 1 of each year beginning with 2011, the Sec-
9 retary shall submit to Congress a report that includes the
10 following:

11 "(1) The information submitted under this sec-
12 tion during the preceding year, aggregated for each
13 applicable manufacturer or distributor of a covered
14 drug, device, biological, or medical supply that sub-
15 mitted such information during such year.

16 "(2) A description of any enforcement actions
17 taken to carry out this section, including any pen-
18 alties imposed under subsection (d), during the pre-
19 ceding year.

20 "(f) DEFINITIONS.—In this section:

21 "(1) APPLICABLE MANUFACTURER; APPLICA-
22 BLE DISTRIBUTOR.—The term 'applicable manufac-
23 turer' means a manufacturer of a covered drug, de-
24 vice, biological, or medical supply, and the term 'ap-

1 plicable distributor' means a distributor of a covered
2 drug, device, or medical supply.
3 "(2) CLINICAL INVESTIGATION.—The term
4 'clinical investigation' means any experiment involv-
5 ing one or more human subjects, or materials de-
6 rived from human subjects, in which a drug or de-
7 vice is administered, dispensed, or used.
8 "(3) COVERED DRUG, DEVICE, BIOLOGICAL, OR
9 MEDICAL SUPPLY.—The term 'covered' means, with
10 respect to a drug, device, biological, or medical sup-
11 ply, such a drug, device, biological, or medical supply
12 for which payment is available under title XVIII or
13 a State plan under title XIX or XXI (or a waiver
14 of such a plan).
15 "(4) COVERED RECIPIENT.—The term 'covered
16 recipient' means the following:
17 "(A) A physician.
18 "(B) A physician group practice.
19 "(C) Any other prescriber of a covered
20 drug, device, biological, or medical supply.
21 "(D) A pharmacy or pharmacist.
22 "(E) A health insurance issuer, group
23 health plan, or other entity offering a health
24 benefits plan, including any employee of such
25 an issuer, plan, or entity.

1 "(F) A pharmacy benefit manager, includ-
2 ing any employee of such a manager.
3 "(G) A hospital.
4 "(H) A medical school.
5 "(I) A sponsor of a continuing medical
6 education program.
7 "(J) A patient advocacy or disease specific
8 group.
9 "(K) A organization of health care profes-
10 sionals.
11 "(L) A biomedical researcher.
12 "(M) A group purchasing organization.
13 "(5) DISTRIBUTOR OF A COVERED DRUG, DE-
14 VICE, OR MEDICAL SUPPLY.—The term 'distributor
15 of a covered drug, device, or medical supply' means
16 any entity which is engaged in the marketing or dis-
17 tribution of a covered drug, device, or medical sup-
18 ply (or any subsidiary of or entity affiliated with
19 such entity), but does not include a wholesale phar-
20 maceutical distributor.
21 "(6) EMPLOYEE.—The term 'employee' has the
22 meaning given such term in section 1877(h)(2).
23 "(7) KNOWINGLY.—The term 'knowingly' has
24 the meaning given such term in section 3729(b) of
25 title 31, United States Code.

1 "(8) MANUFACTURER OF A COVERED DRUG,
2 DEVICE, BIOLOGICAL, OR MEDICAL SUPPLY.—The
3 term 'manufacturer of a covered drug, device, bio-
4 logical, or medical supply' means any entity which is
5 engaged in the production, preparation, propagation,
6 compounding, conversion, processing, marketing, or
7 distribution of a covered drug, device, biological, or
8 medical supply (or any subsidiary of or entity affili-
9 ated with such entity).
10 "(9) PAYMENT OR OTHER TRANSFER OF
11 VALUE.—
12 "(A) IN GENERAL.—The term 'payment or
13 other transfer of value' means a transfer of
14 anything of value for or of any of the following:
15 "(i) Gift, food, or entertainment.
16 "(ii) Travel or trip.
17 "(iii) Honoraria.
18 "(iv) Research funding or grant.
19 "(v) Education or conference funding.
20 "(vi) Consulting fees.
21 "(vii) Ownership or investment inter-
22 est and royalties or license fee.
23 "(B) INCLUSIONS.—Subject to subpara-
24 graph (C), the term 'payment or other transfer
25 of value' includes any compensation, gift, hono-

1 rarium, speaking fee, consulting fee, travel,
2 services, dividend, profit distribution, stock or
3 stock option grant, or any ownership or invest-
4 ment interest held by a physician in a manufac-
5 turer (excluding a dividend or other profit dis-
6 tribution from, or ownership or investment in-
7 terest in, a publicly traded security or mutual
8 fund (as described in section 1877(c))).
9 ''(C) EXCLUSIONS.—The term 'payment or
10 other transfer of value' does not include the fol-
11 lowing:
12 ''(i) Any payment or other transfer of
13 value provided by an applicable manufac-
14 turer or distributor to a covered recipient
15 where the amount transferred to, requested
16 by, or designated on behalf of the covered
17 recipient does not exceed $5.
18 ''(ii) The loan of a covered device for
19 a short-term trial period, not to exceed 90
20 days, to permit evaluation of the covered
21 device by the covered recipient.
22 ''(iii) Items or services provided under
23 a contractual warranty, including the re-
24 placement of a covered device, where the
25 terms of the warranty are set forth in the

1 purchase or lease agreement for the cov-
2 ered device.
3 "(iv) A transfer of anything of value
4 to a covered recipient when the covered re-
5 cipient is a patient and not acting in the
6 professional capacity of a covered recipient.
7 "(v) In-kind items used for the provi-
8 sion of charity care.
9 "(vi) A dividend or other profit dis-
10 tribution from, or ownership or investment
11 interest in, a publicly traded security and
12 mutual fund (as described in section
13 1877(c)).
14 "(vii) Compensation paid by a manu-
15 facturer or distributor of a covered drug,
16 device, biological, or medical supply to a
17 covered recipient who is directly employed
18 by and works solely for such manufacturer
19 or distributor.
20 "(viii) Any discount or cash rebate.
21 "(10) PHYSICIAN.—The term 'physician' has
22 the meaning given that term in section 1861(r). For
23 purposes of this section, such term does not include
24 a physician who is an employee of the applicable

1 manufacturer that is required to submit information
2 under subsection (a).

3 "(g) ANNUAL REPORTS TO STATES.—Not later than
4 April 1 of each year beginning with 2011, the Secretary
5 shall submit to States a report that includes a summary
6 of the information submitted under subsections (a) and
7 (d) during the preceding year with respect to covered re-
8 cipients or other hospitals and entities in the State.

9 "(h) RELATION TO STATE LAWS.—

10 "(1) IN GENERAL.—Effective on January 1,
11 2011, subject to paragraph (2), the provisions of
12 this section shall preempt any law or regulation of
13 a State or of a political subdivision of a State that
14 requires an applicable manufacturer and applicable
15 distributor (as such terms are defined in subsection
16 (f)) to disclose or report, in any format, the type of
17 information (described in subsection (a)) regarding a
18 payment or other transfer of value provided by the
19 manufacturer to a covered recipient (as so defined).

20 "(2) NO PREEMPTION OF ADDITIONAL RE-
21 QUIREMENTS.—Paragraph (1) shall not preempt any
22 law or regulation of a State or of a political subdivi-
23 sion of a State that requires any of the following:

1 "(A) The disclosure or reporting of infor-
2 mation not of the type required to be disclosed
3 or reported under this section.
4 "(B) The disclosure or reporting, in any
5 format, of the type of information required to
6 be disclosed or reported under this section to a
7 Federal, State, or local governmental agency for
8 public health surveillance, investigation, or
9 other public health purposes or health oversight
10 purposes.
11 "(C) The discovery or admissibility of in-
12 formation described in this section in a crimi-
13 nal, civil, or administrative proceeding.".
14 (b) AVAILABILITY OF INFORMATION FROM THE DIS-
15 CLOSURE OF FINANCIAL RELATIONSHIP REPORT
16 (DFRR).—The Secretary of Health and Human Services
17 shall submit to Congress a report on the full results of
18 the Disclosure of Physician Financial Relationships sur-
19 veys required pursuant to section 5006 of the Deficit Re-
20 duction Act of 2005. Such report shall be submitted to
21 Congress not later than the date that is 6 months after
22 the date such surveys are collected and shall be made pub-
23 licly available on an Internet website of the Department
24 of Health and Human Services.

1 ## Subtitle E—Public Reporting on
2 ## Health Care-Associated Infections

3 **SEC. 1461. REQUIREMENT FOR PUBLIC REPORTING BY**
4 **HOSPITALS AND AMBULATORY SURGICAL**
5 **CENTERS ON HEALTH CARE-ASSOCIATED IN-**
6 **FECTIONS.**

7 (a) IN GENERAL.—Title XI of the Social Security Act
8 is amended by inserting after section 1138 the following
9 section:

10 **"SEC. 1138A. REQUIREMENT FOR PUBLIC REPORTING BY**
11 **HOSPITALS AND AMBULATORY SURGICAL**
12 **CENTERS ON HEALTH CARE-ASSOCIATED IN-**
13 **FECTIONS.**

14 ''(a) REPORTING REQUIREMENT.—
15 ''(1) IN GENERAL.—The Secretary shall provide
16 that a hospital (as defined in subsection (g)) or am-
17 bulatory surgical center meeting the requirements of
18 titles XVIII or XIX may participate in the programs
19 established under such titles (pursuant to the appli-
20 cable provisions of law, including sections
21 1866(a)(1) and 1832(a)(1)(F)(i)) only if, in accord-
22 ance with this section, the hospital or center reports
23 such information on health care-associated infections
24 that develop in the hospital or center (and such de-

1 mographic information associated with such infec-
2 tions) as the Secretary specifies.
3 "(2) REPORTING PROTOCOLS.— Such informa-
4 tion shall be reported in accordance with reporting
5 protocols established by the Secretary through the
6 Director of the Centers for Disease Control and Pre-
7 vention (in this section referred to as the 'CDC')
8 and to the National Healthcare Safety Network of
9 the CDC or under such another reporting system of
10 such Centers as determined appropriate by the Sec-
11 retary in consultation with such Director.
12 "(3) COORDINATION WITH HIT.—The Sec-
13 retary, through the Director of the CDC and the Of-
14 fice of the National Coordinator for Health Informa-
15 tion Technology, shall ensure that the transmission
16 of information under this subsection is coordinated
17 with systems established under the HITECH Act,
18 where appropriate.
19 "(4) PROCEDURES TO ENSURE THE VALIDITY
20 OF INFORMATION.—The Secretary shall establish
21 procedures regarding the validity of the information
22 submitted under this subsection in order to ensure
23 that such information is appropriately compared
24 across hospitals and centers. Such procedures shall

1 address failures to report as well as errors in report-
2 ing.

3 "(5) IMPLEMENTATION.—Not later than 1 year
4 after the date of enactment of this section, the Sec-
5 retary, through the Director of CDC, shall promul-
6 gate regulations to carry out this section.

7 "(b) PUBLIC POSTING OF INFORMATION.—The Sec-
8 retary shall promptly post, on the official public Internet
9 site of the Department of Health and Human Services,
10 the information reported under subsection (a). Such infor-
11 mation shall be set forth in a manner that allows for the
12 comparison of information on health care-associated infec-
13 tions—

14 "(1) among hospitals and ambulatory surgical
15 centers; and

16 "(2) by demographic information.

17 "(c) ANNUAL REPORT TO CONGRESS.—On an annual
18 basis the Secretary shall submit to the Congress a report
19 that summarizes each of the following:

20 "(1) The number and types of health care-asso-
21 ciated infections reported under subsection (a) in
22 hospitals and ambulatory surgical centers during
23 such year.

1 "(2) Factors that contribute to the occurrence
2 of such infections, including health care worker im-
3 munization rates.
4 "(3) Based on the most recent information
5 available to the Secretary on the composition of the
6 professional staff of hospitals and ambulatory sur-
7 gical centers, the number of certified infection con-
8 trol professionals on the staff of hospitals and ambu-
9 latory surgical centers.
10 "(4) The total increases or decreases in health
11 care costs that resulted from increases or decreases
12 in the rates of occurrence of each such type of infec-
13 tion during such year.
14 "(5) Recommendations, in coordination with the
15 Center for Quality Improvement established under
16 section 931 of the Public Health Service Act, for
17 best practices to eliminate the rates of occurrence of
18 each such type of infection in hospitals and ambula-
19 tory surgical centers.
20 "(d) NON-PREEMPTION OF STATE LAWS.—Nothing
21 in this section shall be construed as preempting or other-
22 wise affecting any provision of State law relating to the
23 disclosure of information on health care-associated infec-
24 tions or patient safety procedures for a hospital or ambu-
25 latory surgical center.

1 "(e) HEALTH CARE-ASSOCIATED INFECTION.—For
2 purposes of this section:
3 "(1) IN GENERAL.—The term 'health care-asso-
4 ciated infection' means an infection that develops in
5 a patient who has received care in any institutional
6 setting where health care is delivered and is related
7 to receiving health care.
8 "(2) RELATED TO RECEIVING HEALTH CARE.—
9 The term 'related to receiving health care', with re-
10 spect to an infection, means that the infection was
11 not incubating or present at the time health care
12 was provided.
13 "(f) APPLICATION TO CRITICAL ACCESS HOS-
14 PITALS.—For purposes of this section, the term 'hospital'
15 includes a critical access hospital, as defined in section
16 1861(mm)(1).".
17 (b) EFFECTIVE DATE.—With respect to section
18 1138A of the Social Security Act (as inserted by sub-
19 section (a) of this section), the requirement under such
20 section that hospitals and ambulatory surgical centers
21 submit reports takes effect on such date (not later than
22 2 years after the date of the enactment of this Act) as
23 the Secretary of Health and Human Services shall specify.
24 In order to meet such deadline, the Secretary may imple-
25 ment such section through guidance or other instructions.

1 (c) GAO REPORT.—Not later than 18 months after
2 the date of the enactment of this Act, the Comptroller
3 General of the United States shall submit to Congress a
4 report on the program established under section 1138A
5 of the Social Security Act, as inserted by subsection (a).
6 Such report shall include an analysis of the appropriate-
7 ness of the types of information required for submission,
8 compliance with reporting requirements, the success of the
9 validity procedures established, and any conflict or overlap
10 between the reporting required under such section and any
11 other reporting systems mandated by either the States or
12 the Federal Government.
13 (d) REPORT ON ADDITIONAL DATA.—Not later than
14 18 months after the date of the enactment of this Act,
15 the Secretary of Health and Human Services shall submit
16 to the Congress a report on the appropriateness of expand-
17 ing the requirements under such section to include addi-
18 tional information (such as health care worker immuniza-
19 tion rates), in order to improve health care quality and
20 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-

1 erwise applicable resident limit shall be re-
2 duced by 90 percent of the difference be-
3 tween such otherwise applicable resident
4 limit and such reference resident level.
5 ''(ii) REFERENCE RESIDENT LEVEL.—
6 ''(I) IN GENERAL.—Except as
7 otherwise provided in a subsequent
8 subclause, the reference resident level
9 specified in this clause for a hospital
10 is the highest resident level for any of
11 the 3 most recent cost reporting peri-
12 ods (ending before the date of the en-
13 actment of this paragraph) of the hos-
14 pital for which a cost report has been
15 settled (or, if not, submitted (subject
16 to audit)), as determined by the Sec-
17 retary.
18 ''(II) USE OF MOST RECENT AC-
19 COUNTING PERIOD TO RECOGNIZE EX-
20 PANSION OF EXISTING PROGRAMS.—If
21 a hospital submits a timely request to
22 increase its resident level due to an
23 expansion, or planned expansion, of
24 an existing residency training pro-
25 gram that is not reflected on the most

1 recent settled or submitted cost re-
2 port, after audit and subject to the
3 discretion of the Secretary, subject to
4 subclause (IV), the reference resident
5 level for such hospital is the resident
6 level that includes the additional resi-
7 dents attributable to such expansion
8 or establishment, as determined by
9 the Secretary. The Secretary is au-
10 thorized to determine an alternative
11 reference resident level for a hospital
12 that submitted to the Secretary a
13 timely request, before the start of the
14 2009–2010 academic year, for an in-
15 crease in its reference resident level
16 due to a planned expansion.
17 "(III) SPECIAL PROVIDER
18 AGREEMENT.—In the case of a hos-
19 pital described in paragraph
20 (4)(H)(v), the reference resident level
21 specified in this clause is the limita-
22 tion applicable under subclause (I) of
23 such paragraph.
24 "(IV) PREVIOUS REDISTRIBU-
25 TION.—The reference resident level

1 specified in this clause for a hospital
2 shall be increased to the extent re-
3 quired to take into account an in-
4 crease in resident positions made
5 available to the hospital under para-
6 graph (7)(B) that are not otherwise
7 taken into account under a previous
8 subclause.
9 ''(iii) AFFILIATION.—The provisions
10 of clause (i) shall be applied to hospitals
11 which are members of the same affiliated
12 group (as defined by the Secretary under
13 paragraph (4)(H)(ii)) and to the extent the
14 hospitals can demonstrate that they are
15 filling any additional resident slots allo-
16 cated to other hospitals through an affili-
17 ation agreement, the Secretary shall adjust
18 the determination of available slots accord-
19 ingly, or which the Secretary otherwise has
20 permitted the resident positions (under
21 section 402 of the Social Security Amend-
22 ments of 1967) to be aggregated for pur-
23 poses of applying the resident position lim-
24 itations under this subsection.
25 ''(B) REDISTRIBUTION.—

1 "(i) IN GENERAL.—The Secretary
2 shall increase the otherwise applicable resi-
3 dent limit for each qualifying hospital that
4 submits an application under this subpara-
5 graph by such number as the Secretary
6 may approve for portions of cost reporting
7 periods occurring on or after July 1, 2011.
8 The estimated aggregate number of in-
9 creases in the otherwise applicable resident
10 limit under this subparagraph may not ex-
11 ceed the Secretary's estimate of the aggre-
12 gate reduction in such limits attributable
13 to subparagraph (A).
14 "(ii) REQUIREMENTS FOR QUALI-
15 FYING HOSPITALS.—A hospital is not a
16 qualifying hospital for purposes of this
17 paragraph unless the following require-
18 ments are met:
19 "(I) MAINTENANCE OF PRIMARY
20 CARE RESIDENT LEVEL.—The hos-
21 pital maintains the number of primary
22 care residents at a level that is not
23 less than the base level of primary
24 care residents increased by the num-
25 ber of additional primary care resi-

1 dent positions provided to the hospital
2 under this subparagraph. For pur-
3 poses of this subparagraph, the 'base
4 level of primary care residents' for a
5 hospital is the level of such residents
6 as of a base period (specified by the
7 Secretary), determined without regard
8 to whether such positions were in ex-
9 cess of the otherwise applicable resi-
10 dent limit for such period but taking
11 into account the application of sub-
12 clauses (II) and (III) of subparagraph
13 (A)(ii).

14 "(II) DEDICATED ASSIGNMENT
15 OF ADDITIONAL RESIDENT POSITIONS
16 TO PRIMARY CARE.—The hospital as-
17 signs all such additional resident posi-
18 tions for primary care residents.

19 "(III) ACCREDITATION.—The
20 hospital's residency programs in pri-
21 mary care are fully accredited or, in
22 the case of a residency training pro-
23 gram not in operation as of the base
24 year, the hospital is actively applying
25 for such accreditation for the program

1 for such additional resident positions
2 (as determined by the Secretary).
3 ''(iii) CONSIDERATIONS IN REDIS-
4 TRIBUTION.—In determining for which
5 qualifying hospitals the increase in the oth-
6 erwise applicable resident limit is provided
7 under this subparagraph, the Secretary
8 shall take into account the demonstrated
9 likelihood of the hospital filling the posi-
10 tions within the first 3 cost reporting peri-
11 ods beginning on or after July 1, 2011,
12 made available under this subparagraph,
13 as determined by the Secretary.
14 ''(iv) PRIORITY FOR CERTAIN HOS-
15 PITALS.—In determining for which quali-
16 fying hospitals the increase in the other-
17 wise applicable resident limit is provided
18 under this subparagraph, the Secretary
19 shall distribute the increase to qualifying
20 hospitals based on the following criteria:
21 ''(I) The Secretary shall give
22 preference to hospitals that had a re-
23 duction in resident training positions
24 under subparagraph (A).

1 "(II) The Secretary shall give
2 preference to hospitals with 3-year
3 primary care residency training pro-
4 grams, such as family practice and
5 general internal medicine.
6 "(III) The Secretary shall give
7 preference to hospitals insofar as they
8 have in effect formal arrangements
9 (as determined by the Secretary) that
10 place greater emphasis upon training
11 in Federally qualified health centers,
12 rural health clinics, and other nonpro-
13 vider settings, and to hospitals that
14 receive additional payments under
15 subsection (d)(5)(F) and emphasize
16 training in an outpatient department.
17 "(IV) The Secretary shall give
18 preference to hospitals with a number
19 of positions (as of July 1, 2009) in
20 excess of the otherwise applicable resi-
21 dent limit for such period.
22 "(V) The Secretary shall give
23 preference to hospitals that place
24 greater emphasis upon training in a
25 health professional shortage area (des-

1 ignated under section 332 of the Pub-
2 lic Health Service Act) or a health
3 professional needs area (designated
4 under section 2211 of such Act).
5 ''(VI) The Secretary shall give
6 preference to hospitals in States that
7 have low resident-to-population ratios
8 (including a greater preference for
9 those States with lower resident-to-
10 population ratios).
11 ''(v) LIMITATION.—In no case shall
12 more than 20 full-time equivalent addi-
13 tional residency positions be made available
14 under this subparagraph with respect to
15 any hospital.
16 ''(vi) APPLICATION OF PER RESIDENT
17 AMOUNTS FOR PRIMARY CARE.—With re-
18 spect to additional residency positions in a
19 hospital attributable to the increase pro-
20 vided under this subparagraph, the ap-
21 proved FTE resident amounts are deemed
22 to be equal to the hospital per resident
23 amounts for primary care and nonprimary
24 care computed under paragraph (2)(D) for
25 that hospital.

1 "(vii) DISTRIBUTION.—The Secretary
2 shall distribute the increase in resident
3 training positions to qualifying hospitals
4 under this subparagraph not later than
5 July 1, 2011.
6 "(C) RESIDENT LEVEL AND LIMIT DE-
7 FINED.—In this paragraph:
8 "(i) The term 'resident level' has the
9 meaning given such term in paragraph
10 (7)(C)(i).
11 "(ii) The term 'otherwise applicable
12 resident limit' means, with respect to a
13 hospital, the limit otherwise applicable
14 under subparagraphs (F)(i) and (H) of
15 paragraph (4) on the resident level for the
16 hospital determined without regard to this
17 paragraph but taking into account para-
18 graph (7)(A).
19 "(D) MAINTENANCE OF PRIMARY CARE
20 RESIDENT LEVEL.—In carrying out this para-
21 graph, the Secretary shall require hospitals that
22 receive additional resident positions under sub-
23 paragraph (B)—
24 "(i) to maintain records, and periodi-
25 cally report to the Secretary, on the num-

1 ber of primary care residents in its resi-
2 dency training programs; and
3 "(ii) as a condition of payment for a
4 cost reporting period under this subsection
5 for such positions, to maintain the level of
6 such positions at not less than the sum
7 of—
8 "(I) the base level of primary
9 care resident positions (as determined
10 under subparagraph (B)(ii)(I)) before
11 receiving such additional positions;
12 and
13 "(II) the number of such addi-
14 tional positions.".
15 (b) IME.—
16 (1) IN GENERAL.—Section 1886(d)(5)(B)(v) of
17 the Social Security Act (42 U.S.C.
18 1395ww(d)(5)(B)(v)), in the second sentence, is
19 amended—
20 (A) by striking "subsection (h)(7)" and in-
21 serting "subsections (h)(7) and (h)(8)"; and
22 (B) by striking "it applies" and inserting
23 "they apply".
24 (2) CONFORMING PROVISION.—Section
25 1886(d)(5)(B) of the Social Security Act (42 U.S.C.

1 1395ww(d)(5)(B)) is amended by adding at the end
2 the following clause:
3 "(x) For discharges occurring on or after July 1,
4 2011, insofar as an additional payment amount under this
5 subparagraph is attributable to resident positions distrib-
6 uted to a hospital under subsection (h)(8)(B), the indirect
7 teaching adjustment factor shall be computed in the same
8 manner as provided under clause (ii) with respect to such
9 resident positions.".
10 (c) CONFORMING AMENDMENT.—Section 422(b)(2)
11 of the Medicare Prescription Drug, Improvement, and
12 Modernization Act of 2003 (Public Law 108–173) is
13 amended by striking "section 1886(h)(7)" and all that fol-
14 lows and inserting "paragraphs (7) and (8) of subsection
15 (h) of section 1886 of the Social Security Act".

16 **SEC. 1502. INCREASING TRAINING IN NONPROVIDER SET-**
17 **TINGS.**

18 (a) DIRECT GME.—Section 1886(h)(4)(E) of the So-
19 cial Security Act (42 U.S.C. 1395ww(h)) is amended—
20 (1) by designating the first sentence as a clause
21 (i) with the heading "IN GENERAL" and appropriate
22 indentation;
23 (2) by striking "shall be counted and that all
24 the time" and inserting "shall be counted and
25 that—

1 "(I) effective for cost reporting
2 periods beginning before July 1, 2009,
3 all the time";
4 (3) in subclause (I), as inserted by paragraph
5 (1), by striking the period at the end and inserting
6 "; and"; and
7 (A) by inserting after subclause (I), as so
8 inserted, the following:
9 "(II) effective for cost reporting
10 periods beginning on or after July 1,
11 2009, all the time so spent by a resi-
12 dent shall be counted towards the de-
13 termination of full-time equivalency,
14 without regard to the setting in which
15 the activities are performed, if the
16 hospital incurs the costs of the sti-
17 pends and fringe benefits of the resi-
18 dent during the time the resident
19 spends in that setting.
20 Any hospital claiming under this subpara-
21 graph for time spent in a nonprovider set-
22 ting shall maintain and make available to
23 the Secretary records regarding the
24 amount of such time and such amount in
25 comparison with amounts of such time in

1 such base year as the Secretary shall speci-
2 fy.''.
3 (b) IME.—Section 1886(d)(5)(B)(iv) of the Social
4 Security Act (42 U.S.C. 1395ww(d)(5)(B)(iv)) is amend-
5 ed—
6 (1) by striking ''(iv) Effective for discharges oc-
7 curring on or after October 1, 1997'' and inserting
8 ''(iv)(I) Effective for discharges occurring on or
9 after October 1, 1997, and before July 1, 2009'';
10 and
11 (2) by inserting after subclause (I), as inserted
12 by paragraph (1), the following new subclause:
13 ''(II) Effective for discharges occurring on or
14 after July 1, 2009, all the time spent by an intern
15 or resident in patient care activities at an entity in
16 a nonprovider setting shall be counted towards the
17 determination of full-time equivalency if the hospital
18 incurs the costs of the stipends and fringe benefits
19 of the intern or resident during the time the intern
20 or resident spends in that setting.''.
21 (c) OIG STUDY ON IMPACT ON TRAINING.—The In-
22 spector General of the Department of Health and Human
23 Services shall analyze the data collected by the Secretary
24 of Health and Human Services from the records made
25 available to the Secretary under section 1886(h)(4)(E) of

1 the Social Security Act, as amended by subsection (a), in
2 order to assess the extent to which there is an increase
3 in time spent by medical residents in training in nonpro-
4 vider settings as a result of the amendments made by this
5 section. Not later than 4 years after the date of the enact-
6 ment of this Act, the Inspector General shall submit a re-
7 port to Congress on such analysis and assessment.

8 (d) DEMONSTRATION PROJECT FOR APPROVED
9 TEACHING HEALTH CENTERS.—

10 (1) IN GENERAL.—The Secretary of Health and
11 Human Services shall conduct a demonstration
12 project under which an approved teaching health
13 center (as defined in paragraph (3)) would be eligi-
14 ble for payment under subsections (h) and (k) of
15 section 1886 of the Social Security Act (42 U.S.C.
16 1395ww) of amounts for its own direct costs of
17 graduate medical education activities for primary
18 care residents, as well as for the direct costs of grad-
19 uate medical education activities of its contracting
20 hospital for such residents, in a manner similar to
21 the manner in which such payments would be made
22 to a hospital if the hospital were to operate such a
23 program.

24 (2) CONDITIONS.—Under the demonstration
25 project—

1 (A) an approved teaching health center
2 shall contract with an accredited teaching hos-
3 pital to carry out the inpatient responsibilities
4 of the primary care residency program of the
5 hospital involved and is responsible for payment
6 to the hospital for the hospital's costs of the
7 salary and fringe benefits for residents in the
8 program;
9 (B) the number of primary care residents
10 of the center shall not count against the con-
11 tracting hospital's resident limit; and
12 (C) the contracting hospital shall agree not
13 to diminish the number of residents in its pri-
14 mary care residency training program.
15 (3) APPROVED TEACHING HEALTH CENTER DE-
16 FINED.—In this subsection, the term ''approved
17 teaching health center'' means a nonprovider setting,
18 such as a Federally qualified health center or rural
19 health clinic (as defined in section 1861(aa) of the
20 Social Security Act), that develops and operates an
21 accredited primary care residency program for which
22 funding would be available if it were operated by a
23 hospital.

1 **SEC. 1503. RULES FOR COUNTING RESIDENT TIME FOR DI-**
2 **DACTIC AND SCHOLARLY ACTIVITIES AND**
3 **OTHER ACTIVITIES.**

4 (a) DIRECT GME.—Section 1886(h) of the Social Se-
5 curity Act (42 U.S.C. 1395ww(h)) is amended—
6 (1) in paragraph (4)(E), as amended by section
7 1502(a)—
8 (A) in clause (i), by striking "Such rules"
9 and inserting "Subject to clause (ii), such
10 rules"; and
11 (B) by adding at the end the following new
12 clause:
13 "(ii) TREATMENT OF CERTAIN NON-
14 PROVIDER AND DIDACTIC ACTIVITIES.—
15 Such rules shall provide that all time spent
16 by an intern or resident in an approved
17 medical residency training program in a
18 nonprovider setting that is primarily en-
19 gaged in furnishing patient care (as de-
20 fined in paragraph (5)(K)) in nonpatient
21 care activities, such as didactic conferences
22 and seminars, but not including research
23 not associated with the treatment or diag-
24 nosis of a particular patient, as such time
25 and activities are defined by the Secretary,

1 shall be counted toward the determination
2 of full-time equivalency.'';
3 (2) in paragraph (4), by adding at the end the
4 following new subparagraph:
5 ''(I) In determining the hospital's number
6 of full-time equivalent residents for purposes of
7 this subsection, all the time that is spent by an
8 intern or resident in an approved medical resi-
9 dency training program on vacation, sick leave,
10 or other approved leave, as such time is defined
11 by the Secretary, and that does not prolong the
12 total time the resident is participating in the
13 approved program beyond the normal duration
14 of the program shall be counted toward the de-
15 termination of full-time equivalency.''; and
16 (3) in paragraph (5), by adding at the end the
17 following new subparagraph:
18 ''(K) NONPROVIDER SETTING THAT IS PRI-
19 MARILY ENGAGED IN FURNISHING PATIENT
20 CARE.—The term 'nonprovider setting that is
21 primarily engaged in furnishing patient care'
22 means a nonprovider setting in which the pri-
23 mary activity is the care and treatment of pa-
24 tients, as defined by the Secretary.''.

1 (b) IME DETERMINATIONS.—Section 1886(d)(5)(B)
2 of such Act (42 U.S.C. 1395ww(d)(5)(B)), as amended by
3 section 1501(b), is amended by adding at the end the fol-
4 lowing new clause:
5 "(xi)(I) The provisions of subparagraph (I) of sub-
6 section (h)(4) shall apply under this subparagraph in the
7 same manner as they apply under such subsection.
8 "(II) In determining the hospital's number of full-
9 time equivalent residents for purposes of this subpara-
10 graph, all the time spent by an intern or resident in an
11 approved medical residency training program in non-
12 patient care activities, such as didactic conferences and
13 seminars, as such time and activities are defined by the
14 Secretary, that occurs in the hospital shall be counted to-
15 ward the determination of full-time equivalency if the hos-
16 pital—
17 "(aa) is recognized as a subsection (d) hospital;
18 "(bb) is recognized as a subsection (d) Puerto
19 Rico hospital;
20 "(cc) is reimbursed under a reimbursement sys-
21 tem authorized under section 1814(b)(3); or
22 "(dd) is a provider-based hospital outpatient de-
23 partment.
24 "(III) In determining the hospital's number of full-
25 time equivalent residents for purposes of this subpara-

1 graph, all the time spent by an intern or resident in an
2 approved medical residency training program in research
3 activities that are not associated with the treatment or di-
4 agnosis of a particular patient, as such time and activities
5 are defined by the Secretary, shall not be counted toward
6 the determination of full-time equivalency.''.

7 (c) EFFECTIVE DATES; APPLICATION.—

8 (1) IN GENERAL.—Except as otherwise pro-
9 vided, the Secretary of Health and Human Services
10 shall implement the amendments made by this sec-
11 tion in a manner so as to apply to cost reporting pe-
12 riods beginning on or after January 1, 1983.

13 (2) DIRECT GME.—Section 1886(h)(4)(E)(ii) of
14 the Social Security Act, as added by subsection
15 (a)(1)(B), shall apply to cost reporting periods be-
16 ginning on or after July 1, 2008.

17 (3) IME.—Section 1886(d)(5)(B)(x)(III) of the
18 Social Security Act, as added by subsection (b), shall
19 apply to cost reporting periods beginning on or after
20 October 1, 2001. Such section, as so added, shall
21 not give rise to any inference on how the law in ef-
22 fect prior to such date should be interpreted.

23 (4) APPLICATION.—The amendments made by
24 this section shall not be applied in a manner that re-
25 quires reopening of any settled hospital cost reports

1 as to which there is not a jurisdictionally proper ap-
2 peal pending as of the date of the enactment of this
3 Act on the issue of payment for indirect costs of
4 medical education under section 1886(d)(5)(B) of
5 the Social Security Act or for direct graduate med-
6 ical education costs under section 1886(h) of such
7 Act.

8 **SEC. 1504. PRESERVATION OF RESIDENT CAP POSITIONS**
9 **FROM CLOSED HOSPITALS.**

10 (a) DIRECT GME.—Section 1886(h)(4)(H) of the So-
11 cial Security Act (42 U.S.C. Section 1395ww(h)(4)(H))
12 is amended by adding at the end the following new clause:
13 "(vi) REDISTRIBUTION OF RESIDENCY
14 SLOTS AFTER A HOSPITAL CLOSES.—
15 "(I) IN GENERAL.—The Sec-
16 retary shall, by regulation, establish a
17 process consistent with subclauses (II)
18 and (III) under which, in the case
19 where a hospital (other than a hos-
20 pital described in clause (v)) with an
21 approved medical residency program
22 in a State closes on or after the date
23 that is 2 years before the date of the
24 enactment of this clause, the Sec-
25 retary shall increase the otherwise ap-

1 plicable resident limit under this para-
2 graph for other hospitals in the State
3 in accordance with this clause.

4 "(II) PROCESS FOR HOSPITALS
5 IN CERTAIN AREAS.—In determining
6 for which hospitals the increase in the
7 otherwise applicable resident limit de-
8 scribed in subclause (I) is provided,
9 the Secretary shall establish a process
10 to provide for such increase to one or
11 more hospitals located in the State.
12 Such process shall take into consider-
13 ation the recommendations submitted
14 to the Secretary by the senior health
15 official (as designated by the chief ex-
16 ecutive officer of such State) if such
17 recommendations are submitted not
18 later than 180 days after the date of
19 the hospital closure involved (or, in
20 the case of a hospital that closed after
21 the date that is 2 years before the
22 date of the enactment of this clause,
23 180 days after such date of enact-
24 ment).

1 "(III) LIMITATION.—The esti-
2 mated aggregate number of increases
3 in the otherwise applicable resident
4 limits for hospitals under this clause
5 shall be equal to the estimated num-
6 ber of resident positions in the ap-
7 proved medical residency programs
8 that closed on or after the date de-
9 scribed in subclause (I).".

10 (b) NO EFFECT ON TEMPORARY FTE CAP ADJUST-
11 MENTS.—The amendments made by this section shall not
12 effect any temporary adjustment to a hospital's FTE cap
13 under section 413.79(h) of title 42, Code of Federal Regu-
14 lations (as in effect on the date of enactment of this Act)
15 and shall not affect the application of section
16 1886(h)(4)(H)(v) of the Social Security Act.

17 (c) CONFORMING AMENDMENTS.—

18 (1) Section 422(b)(2) of the Medicare Prescrip-
19 tion Drug, Improvement, and Modernization Act of
20 2003 (Public Law 108–173), as amended by section
21 1501(c), is amended by striking "(7) and" and in-
22 serting "(4)(H)(vi), (7), and".

23 (2) Section 1886(h)(7)(E) of the Social Secu-
24 rity Act (42 U.S.C. 1395ww(h)(7)(E)) is amended

1 by inserting ''or under paragraph (4)(H)(vi)'' after
2 ''under this paragraph''.

3 **SEC. 1505. IMPROVING ACCOUNTABILITY FOR APPROVED**
4 **MEDICAL RESIDENCY TRAINING.**

5 (a) SPECIFICATION OF GOALS FOR APPROVED MED-
6 ICAL RESIDENCY TRAINING PROGRAMS.—Section
7 1886(h)(1) of the Social Security Act (42 U.S.C.
8 1395ww(h)(1)) is amended—
9 (1) by designating the matter beginning with
10 ''Notwithstanding'' as a subparagraph (A) with the
11 heading ''IN GENERAL.—'' and with appropriate in-
12 dentation; and
13 (2) by adding at the end the following new
14 paragraph:
15 ''(B) GOALS AND ACCOUNTABILITY FOR
16 APPROVED MEDICAL RESIDENCY TRAINING PRO-
17 GRAMS.—The goals of medical residency train-
18 ing programs are to foster a physician work-
19 force so that physicians are trained to be able
20 to do the following:
21 ''(i) Work effectively in various health
22 care delivery settings, such as nonprovider
23 settings.

1 "(ii) Coordinate patient care within
2 and across settings relevant to their spe-
3 cialties.
4 "(iii) Understand the relevant cost
5 and value of various diagnostic and treat-
6 ment options.
7 "(iv) Work in inter-professional teams
8 and multi-disciplinary team-based models
9 in provider and nonprovider settings to en-
10 hance safety and improve quality of patient
11 care.
12 "(v) Be knowledgeable in methods of
13 identifying systematic errors in health care
14 delivery and in implementing systematic
15 solutions in case of such errors, including
16 experience and participation in continuous
17 quality improvement projects to improve
18 health outcomes of the population the phy-
19 sicians serve.
20 "(vi) Be meaningful EHR users (as
21 determined under section 1848(o)(2)) in
22 the delivery of care and in improving the
23 quality of the health of the community and
24 the individuals that the hospital serves."

1 (b) GAO STUDY ON EVALUATION OF TRAINING PRO-
2 GRAMS.—
3 (1) IN GENERAL.—The Comptroller General of
4 the United States shall conduct a study to evaluate
5 the extent to which medical residency training pro-
6 grams—
7 (A) are meeting the goals described in sec-
8 tion 1886(h)(1)(B) of the Social Security Act,
9 as added by subsection (a), in a range of resi-
10 dency programs, including primary care and
11 other specialties; and
12 (B) have the appropriate faculty expertise
13 to teach the topics required to achieve such
14 goals.
15 (2) REPORT.—Not later than 18 months after
16 the date of the enactment of this Act, the Comp-
17 troller General shall submit to Congress a report on
18 such study and shall include in such report rec-
19 ommendations as to how medical residency training
20 programs could be further encouraged to meet such
21 goals through means such as—
22 (A) development of curriculum require-
23 ments; and
24 (B) assessment of the accreditation proc-
25 esses of the Accreditation Council for Graduate

1 Medical Education and the American Osteo-
2 pathic Association and effectiveness of those
3 processes in accrediting medical residency pro-
4 grams that meet the goals referred to in para-
5 graph (1)(A).

6 TITLE VI—PROGRAM INTEGRITY

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

9 SEC. 1601. INCREASED FUNDING AND FLEXIBILITY TO
10 FIGHT FRAUD AND ABUSE.

11 (a) IN GENERAL.—Section 1817(k) of the Social Se-
12 curity Act (42 U.S.C. 1395i(k)) is amended—
13 (1) by adding at the end the following new
14 paragraph:
15 ''(7) ADDITIONAL FUNDING.—In addition to the
16 funds otherwise appropriated to the Account from
17 the Trust Fund under paragraphs (3) and (4) and
18 for purposes described in paragraphs (3)(C) and
19 (4)(A), there are hereby appropriated an additional
20 $100,000,000 to such Account from such Trust
21 Fund for each fiscal year beginning with 2011. The
22 funds appropriated under this paragraph shall be al-
23 located in the same proportion as the total funding
24 appropriated with respect to paragraphs (3)(A) and
25 (4)(A) was allocated with respect to fiscal year

1 2010, and shall be available without further appro-
2 priation until expended.''.
3 (2) in paragraph (4)(A)—
4 (A) by inserting ''for activities described in
5 paragraph (3)(C) and'' after ''necessary''; and
6 (B) by inserting ''until expended'' after
7 ''appropriation''.
8 (b) FLEXIBILITY IN PURSUING FRAUD AND
9 ABUSE.—Section 1893(a) of the Social Security Act (42
10 U.S.C. 1395ddd(a)) is amended by inserting '', or other-
11 wise,'' after ''entities''.

12 Subtitle B—Enhanced Penalties for 13 Fraud and Abuse

14 SEC. 1611. ENHANCED PENALTIES FOR FALSE STATEMENTS 15 ON PROVIDER OR SUPPLIER ENROLLMENT 16 APPLICATIONS.

17 (a) IN GENERAL.—Section 1128A(a) of the Social
18 Security Act (42 U.S.C. 1320a–7a(a)) is amended—
19 (1) in paragraph (1)(D), by striking all that fol-
20 lows ''in which the person was excluded'' and insert-
21 ing ''under Federal law from the Federal health care
22 program under which the claim was made, or'';
23 (2) by striking ''or'' at the end of paragraph
24 (6);

1 (3) in paragraph (7), by inserting at the end
2 ‘‘or’’;
3 (4) by inserting after paragraph (7) the fol-
4 lowing new paragraph:
5 ‘‘(8) knowingly makes or causes to be made any
6 false statement, omission, or misrepresentation of a
7 material fact in any application, agreement, bid, or
8 contract to participate or enroll as a provider of
9 services or supplier under a Federal health care pro-
10 gram, including managed care organizations under
11 title XIX, Medicare Advantage organizations under
12 part C of title XVIII, prescription drug plan spon-
13 sors under part D of title XVIII, and entities that
14 apply to participate as providers of services or sup-
15 pliers in such managed care organizations and such
16 plans;’’;
17 (5) in the matter following paragraph (8), as
18 inserted by paragraph (4), by striking ‘‘or in cases
19 under paragraph (7), $ 50,000 for each such act)’’
20 and inserting ‘‘in cases under paragraph (7),
21 $50,000 for each such act, or in cases under para-
22 graph (8), $50,000 for each false statement, omis-
23 sion, or misrepresentation of a material fact)’’; and
24 (6) in the second sentence, by striking ‘‘for a
25 lawful purpose)’’ and inserting ‘‘for a lawful pur-

1 pose, or in cases under paragraph (8), an assess-
2 ment of not more than 3 times the amount claimed
3 as the result of the false statement, omission, or
4 misrepresentation of material fact claimed by a pro-
5 vider of services or supplier whose application to
6 participate contained such false statement, omission,
7 or misrepresentation)''.
8 (b) EFFECTIVE DATE.—The amendments made by
9 subsection (a) shall apply to acts committed on or after
10 January 1, 2010.

11 **SEC. 1612. ENHANCED PENALTIES FOR SUBMISSION OF**
12 **FALSE STATEMENTS MATERIAL TO A FALSE**
13 **CLAIM.**

14 (a) IN GENERAL.—Section 1128A(a) of the Social
15 Security Act (42 U.S.C. 1320a–7a(a)), as amended by sec-
16 tion 1611, is further amended—
17 (1) in paragraph (7), by striking ''or'' at the
18 end;
19 (2) in paragraph (8), by inserting ''or'' at the
20 end; and
21 (3) by inserting after paragraph (8), the fol-
22 lowing new paragraph:
23 ''(9) knowingly makes, uses, or causes to be
24 made or used, a false record or statement material
25 to a false or fraudulent claim for payment for items

1 and services furnished under a Federal health care
2 program;''; and
3 (4) in the matter following paragraph (9), as
4 inserted by paragraph (3)—
5 (A) by striking ''or in cases under para-
6 graph (8)'' and inserting ''in cases under para-
7 graph (8)''; and
8 (B) by striking ''a material fact)'' and in-
9 serting ''a material fact, in cases under para-
10 graph (9), $50,000 for each false record or
11 statement)''.
12 (b) EFFECTIVE DATE.—The amendments made by
13 subsection (a) shall apply to acts committed on or after
14 January 1, 2010.
15 **SEC. 1613. ENHANCED PENALTIES FOR DELAYING INSPEC-**
16 **TIONS.**
17 (a) IN GENERAL.—Section 1128A(a) of the Social
18 Security Act (42 U.S.C. 1320a–7a(a)), as amended by sec-
19 tions 1611 and 1612, is further amended—
20 (1) in paragraph (8), by striking ''or'' at the
21 end;
22 (2) in paragraph (9), by inserting ''or'' at the
23 end;
24 (3) by inserting after paragraph (9) the fol-
25 lowing new paragraph:

1 "(10) fails to grant timely access, upon reason-
2 able request (as defined by the Secretary in regula-
3 tions), to the Inspector General of the Department
4 of Health and Human Services, for the purpose of
5 audits, investigations, evaluations, or other statutory
6 functions of the Inspector General of the Depart-
7 ment of Health and Human Services;"; and
8 (4) in the matter following paragraph (10), as
9 inserted by paragraph (3)—
10 (A) by striking "or" after "$50,000 for
11 each such act,"; and
12 (B) by inserting ", or in cases under para-
13 graph (10), $15,000 for each day of the failure
14 described in such paragraph" after "false
15 record or statement".
16 (b) ENSURING TIMELY INSPECTIONS RELATING TO
17 CONTRACTS WITH MA ORGANIZATIONS.—Section
18 1857(d)(2) of such Act (42 U.S.C. 1395w–27(d)(2)) is
19 amended—
20 (1) in subparagraph (A), by inserting "timely"
21 before "inspect"; and
22 (2) in subparagraph (B), by inserting "timely"
23 before "audit and inspect".

1 (c) EFFECTIVE DATE.—The amendments made by
2 subsection (a) shall apply to violations committed on or
3 after January 1, 2010.

4 **SEC. 1614. ENHANCED HOSPICE PROGRAM SAFEGUARDS.**

5 (a) MEDICARE.—Part A of title XVIII of the Social
6 Security Act is amended by inserting after section 1819
7 the following new section:

8 **"SEC. 1819A. ASSURING QUALITY OF CARE IN HOSPICE**
9 **CARE.**

10 "(a) IN GENERAL.—If the Secretary determines on
11 the basis of a survey or otherwise, that a hospice program
12 that is certified for participation under this title has dem-
13 onstrated a substandard quality of care and failed to meet
14 such other requirements as the Secretary may find nec-
15 essary in the interest of the health and safety of the indi-
16 viduals who are provided care and services by the agency
17 or organization involved and determines—

18 "(1) that the deficiencies involved immediately
19 jeopardize the health and safety of the individuals to
20 whom the program furnishes items and services, the
21 Secretary shall take immediate action to remove the
22 jeopardy and correct the deficiencies through the
23 remedy specified in subsection (b)(2)(A)(iii) or ter-
24 minate the certification of the program, and may

1 provide, in addition, for 1 or more of the other rem-
2 edies described in subsection (b)(2)(A); or
3 ''(2) that the deficiencies involved do not imme-
4 diately jeopardize the health and safety of the indi-
5 viduals to whom the program furnishes items and
6 services, the Secretary may—
7 ''(A) impose intermediate sanctions devel-
8 oped pursuant to subsection (b), in lieu of ter-
9 minating the certification of the program; and
10 ''(B) if, after such a period of intermediate
11 sanctions, the program is still not in compliance
12 with such requirements, the Secretary shall ter-
13 minate the certification of the program.
14 If the Secretary determines that a hospice program
15 that is certified for participation under this title is
16 in compliance with such requirements but, as of a
17 previous period, was not in compliance with such re-
18 quirements, the Secretary may provide for a civil
19 money penalty under subsection (b)(2)(A)(i) for the
20 days in which it finds that the program was not in
21 compliance with such requirements.
22 ''(b) INTERMEDIATE SANCTIONS.—
23 ''(1) DEVELOPMENT AND IMPLEMENTATION.—
24 The Secretary shall develop and implement, by not
25 later than July 1, 2012—

1 “(A) a range of intermediate sanctions to
2 apply to hospice programs under the conditions
3 described in subsection (a), and
4 “(B) appropriate procedures for appealing
5 determinations relating to the imposition of
6 such sanctions.
7 “(2) SPECIFIED SANCTIONS.—
8 “(A) IN GENERAL.—The intermediate
9 sanctions developed under paragraph (1) may
10 include—
11 “(i) civil money penalties in an
12 amount not to exceed $10,000 for each day
13 of noncompliance or, in the case of a per
14 instance penalty applied by the Secretary,
15 not to exceed $25,000,
16 “(ii) denial of all or part of the pay-
17 ments to which a hospice program would
18 otherwise be entitled under this title with
19 respect to items and services furnished by
20 a hospice program on or after the date on
21 which the Secretary determines that inter-
22 mediate sanctions should be imposed pur-
23 suant to subsection (a)(2),
24 “(iii) the appointment of temporary
25 management to oversee the operation of

1 the hospice program and to protect and as-
2 sure the health and safety of the individ-
3 uals under the care of the program while
4 improvements are made,
5 "(iv) corrective action plans, and
6 "(v) in-service training for staff.
7 The provisions of section 1128A (other than
8 subsections (a) and (b)) shall apply to a civil
9 money penalty under clause (i) in the same
10 manner as such provisions apply to a penalty or
11 proceeding under section 1128A(a). The tem-
12 porary management under clause (iii) shall not
13 be terminated until the Secretary has deter-
14 mined that the program has the management
15 capability to ensure continued compliance with
16 all requirements referred to in that clause.
17 "(B) CLARIFICATION.—The sanctions
18 specified in subparagraph (A) are in addition to
19 sanctions otherwise available under State or
20 Federal law and shall not be construed as lim-
21 iting other remedies, including any remedy
22 available to an individual at common law.
23 "(C) COMMENCEMENT OF PAYMENT.—A
24 denial of payment under subparagraph (A)(ii)
25 shall terminate when the Secretary determines

1 that the hospice program no longer dem-
2 onstrates a substandard quality of care and
3 meets such other requirements as the Secretary
4 may find necessary in the interest of the health
5 and safety of the individuals who are provided
6 care and services by the agency or organization
7 involved.

8 ''(3) SECRETARIAL AUTHORITY.—The Secretary
9 shall develop and implement, by not later than July
10 1, 2011, specific procedures with respect to the con-
11 ditions under which each of the intermediate sanc-
12 tions developed under paragraph (1) is to be applied,
13 including the amount of any fines and the severity
14 of each of these sanctions. Such procedures shall be
15 designed so as to minimize the time between identi-
16 fication of deficiencies and imposition of these sanc-
17 tions and shall provide for the imposition of incre-
18 mentally more severe fines for repeated or uncor-
19 rected deficiencies.''.

20 (b) APPLICATION TO MEDICAID.—Section 1905(o) of
21 the Social Security Act (42 U.S.C. 1396d(o)) is amended
22 by adding at the end the following new paragraph:

23 ''(4) The provisions of section 1819A shall apply to
24 a hospice program providing hospice care under this title

1 in the same manner as such provisions apply to a hospice
2 program providing hospice care under title XVIII.''.
3 (c) APPLICATION TO CHIP.—Title XXI of the Social
4 Security Act is amended by adding at the end the fol-
5 lowing new section:

6 **''SEC. 2114. ASSURING QUALITY OF CARE IN HOSPICE CARE.**

7 ''The provisions of section 1819A shall apply to a
8 hospice program providing hospice care under this title in
9 the same manner such provisions apply to a hospice pro-
10 gram providing hospice care under title XVIII.''.

11 **SEC. 1615. ENHANCED PENALTIES FOR INDIVIDUALS EX-**
12 **CLUDED FROM PROGRAM PARTICIPATION.**

13 (a) IN GENERAL.—Section 1128A(a) of the Social
14 Security Act (42 U.S.C. 1320a–7a(a)), as amended by the
15 previous sections, is further amended—
16 (1) by striking ''or'' at the end of paragraph
17 (9);
18 (2) by inserting ''or'' at the end of paragraph
19 (10);
20 (3) by inserting after paragraph (10) the fol-
21 lowing new paragraph:
22 ''(11) orders or prescribes an item or service,
23 including without limitation home health care, diag-
24 nostic and clinical lab tests, prescription drugs, du-
25 rable medical equipment, ambulance services, phys-

1 ical or occupational therapy, or any other item or
2 service, during a period when the person has been
3 excluded from participation in a Federal health care
4 program, and the person knows or should know that
5 a claim for such item or service will be presented to
6 such a program;''; and
7 (4) in the matter following paragraph (11), as
8 inserted by paragraph (2), by striking ''$15,000 for
9 each day of the failure described in such paragraph''
10 and inserting ''$15,000 for each day of the failure
11 described in such paragraph, or in cases under para-
12 graph (11), $50,000 for each order or prescription
13 for an item or service by an excluded individual''.
14 (b) EFFECTIVE DATE.—The amendments made by
15 subsection (a) shall apply to violations committed on or
16 after January 1, 2010.

17 **SEC. 1616. ENHANCED PENALTIES FOR PROVISION OF**
18 **FALSE INFORMATION BY MEDICARE ADVAN-**
19 **TAGE AND PART D PLANS.**

20 (a) IN GENERAL.—Section 1857(g)(2)(A) of the So-
21 cial Security Act (42 U.S.C. 1395w—27(g)(2)(A)) is
22 amended by inserting ''except with respect to a determina-
23 tion under subparagraph (E), an assessment of not more
24 than 3 times the amount claimed by such plan or plan

1 sponsor based upon the misrepresentation or falsified in-
2 formation involved,'' after ''for each such determination,''.
3 (b) EFFECTIVE DATE.—The amendment made by
4 subsection (a) shall apply to violations committed on or
5 after January 1, 2010.

6 **SEC. 1617. ENHANCED PENALTIES FOR MEDICARE ADVAN-**
7 **TAGE AND PART D MARKETING VIOLATIONS.**

8 (a) IN GENERAL.—Section 1857(g)(1) of the Social
9 Security Act (42 U.S.C. 1395w—27(g)(1)), as amended
10 by section 1221(b), is amended—
11 (1) in subparagraph (G), by striking ''or'' at
12 the end;
13 (2) by inserting after subparagraph (H) the fol-
14 lowing new subparagraphs:
15 ''(I) except as provided under subpara-
16 graph (C) or (D) of section 1860D–1(b)(1), en-
17 rolls an individual in any plan under this part
18 without the prior consent of the individual or
19 the designee of the individual;
20 ''(J) transfers an individual enrolled under
21 this part from one plan to another without the
22 prior consent of the individual or the designee
23 of the individual or solely for the purpose of
24 earning a commission;

1 "(K) fails to comply with marketing re-
2 strictions described in subsections (h) and (j) of
3 section 1851 or applicable implementing regula-
4 tions or guidance; or

5 "(L) employs or contracts with any indi-
6 vidual or entity who engages in the conduct de-
7 scribed in subparagraphs (A) through (K) of
8 this paragraph;"; and

9 (3) by adding at the end the following new sen-
10 tence: "The Secretary may provide, in addition to
11 any other remedies authorized by law, for any of the
12 remedies described in paragraph (2), if the Secretary
13 determines that any employee or agent of such orga-
14 nization, or any provider or supplier who contracts
15 with such organization, has engaged in any conduct
16 described in subparagraphs (A) through (L) of this
17 paragraph."

18 (b) EFFECTIVE DATE.—The amendments made by
19 subsection (a) shall apply to violations committed on or
20 after January 1, 2010.

21 **SEC. 1618. ENHANCED PENALTIES FOR OBSTRUCTION OF**
22 **PROGRAM AUDITS.**

23 (a) IN GENERAL.—Section 1128(b)(2) of the Social
24 Security Act (42 U.S.C. 1320a–7(b)(2)) is amended—

1 (1) in the heading, by inserting "OR AUDIT"
2 after "INVESTIGATION"; and
3 (2) by striking "investigation into" and all that
4 follows through the period and inserting "investiga-
5 tion or audit related to—"
6 "(i) any offense described in para-
7 graph (1) or in subsection (a); or
8 "(ii) the use of funds received, directly
9 or indirectly, from any Federal health care
10 program (as defined in section
11 1128B(f)).".
12 (b) EFFECTIVE DATE.—The amendments made by
13 subsection (a) shall apply to violations committed on or
14 after January 1, 2010.

15 **SEC. 1619. EXCLUSION OF CERTAIN INDIVIDUALS AND EN-**
16 **TITIES FROM PARTICIPATION IN MEDICARE**
17 **AND STATE HEALTH CARE PROGRAMS.**

18 (a) IN GENERAL.—Section 1128(c) of the Social Se-
19 curity Act, as previously amended by this division, is fur-
20 ther amended—
21 (1) in the heading, by striking "AND PERIOD"
22 and inserting ", PERIOD, AND EFFECT"; and
23 (2) by adding at the end the following new
24 paragraph:

1 "(4)(A) For purposes of this Act, subject to
2 subparagraph (C), the effect of exclusion is that no
3 payment may be made by any Federal health care
4 program (as defined in section 1128B(f)) with re-
5 spect to any item or service furnished—
6 "(i) by an excluded individual or entity; or
7 "(ii) at the medical direction or on the pre-
8 scription of a physician or other authorized in-
9 dividual when the person submitting a claim for
10 such item or service knew or had reason to
11 know of the exclusion of such individual.
12 "(B) For purposes of this section and sections
13 1128A and 1128B, subject to subparagraph (C), an
14 item or service has been furnished by an individual
15 or entity if the individual or entity directly or indi-
16 rectly provided, ordered, manufactured, distributed,
17 prescribed, or otherwise supplied the item or service
18 regardless of how the item or service was paid for
19 by a Federal health care program or to whom such
20 payment was made.
21 "(C)(i) Payment may be made under a Federal
22 health care program for emergency items or services
23 (not including items or services furnished in an
24 emergency room of a hospital) furnished by an ex-
25 cluded individual or entity, or at the medical direc-

1 tion or on the prescription of an excluded physician
2 or other authorized individual during the period of
3 such individual's exclusion.
4 "(ii) In the case that an individual eligible for
5 benefits under title XVIII or XIX submits a claim
6 for payment for items or services furnished by an ex-
7 cluded individual or entity, and such individual eligi-
8 ble for such benefits did not know or have reason to
9 know that such excluded individual or entity was so
10 excluded, then, notwithstanding such exclusion, pay-
11 ment shall be made for such items or services. In
12 such case the Secretary shall notify such individual
13 eligible for such benefits of the exclusion of the indi-
14 vidual or entity furnishing the items or services.
15 Payment shall not be made for items or services fur-
16 nished by an excluded individual or entity to an indi-
17 vidual eligible for such benefits after a reasonable
18 time (as determined by the Secretary in regulations)
19 after the Secretary has notified the individual eligi-
20 ble for such benefits of the exclusion of the indi-
21 vidual or entity furnishing the items or services.
22 "(iii) In the case that a claim for payment for
23 items or services furnished by an excluded individual
24 or entity is submitted by an individual or entity
25 other than an individual eligible for benefits under

1 title XVIII or XIX or the excluded individual or en-
2 tity, and the Secretary determines that the indi-
3 vidual or entity that submitted the claim took rea-
4 sonable steps to learn of the exclusion and reason-
5 ably relied upon inaccurate or misleading informa-
6 tion from the relevant Federal health care program
7 or its contractor, the Secretary may waive repay-
8 ment of the amount paid in violation of the exclusion
9 to the individual or entity that submitted the claim
10 for the items or services furnished by the excluded
11 individual or entity. If a Federal health care pro-
12 gram contractor provided inaccurate or misleading
13 information that resulted in the waiver of an over-
14 payment under this clause, the Secretary shall take
15 appropriate action to recover the improperly paid
16 amount from the contractor.''.

17 **SEC. 1620. ENFORCEMENT OF MEDICARE SECONDARY**
18 **PAYER PROVISIONS.**

19 Section 1862(b) of the Social Security Act (42 U.S.C.
20 1395y(b)) is amended—
21 (1) in paragraph (2)(B)(ii)—
22 (A) in the first sentence, by inserting ''has
23 or had, or upon demonstration, will have'' after
24 ''such primary plan'';

1 (B) in the first sentence, by inserting
2 "under the terms of such primary plan or the
3 relevant substantive provisions of law, including
4 State tort law" before the period at the end;
5 (C) in the second sentence, by striking "by
6 a judgment," and inserting "in the context of
7 an action brought under clause (iii) or (iv) of
8 subparagraph (B), or under paragraph (3)(A),
9 by a judgment, by";
10 (D) in the second sentence, by striking "or
11 by other means" and inserting "by a judgment,
12 opinion, or other adjudication finding facts that
13 establish a primary plan's responsibility for any
14 such payment (whether or not such finding has
15 been appealed), by any relevant evidence, in-
16 cluding but not limited to relevant statistical or
17 epidemiological evidence, or by other similarly
18 reliable means"; and
19 (E) by inserting after the second sentence
20 the following new sentence: "A single action
21 may be brought under clause (iii) or (iv) of sub-
22 paragraph (B), or paragraph (3)(A) to establish
23 the responsibility of an entity to make payment
24 for all items and services furnished to all indi-
25 viduals for which that entity is alleged to be the

1 primary plan and to recover damages as pro-
2 vided in clause (iii) or (iv) of subparagraph (B)
3 or paragraph (3)(A).'';
4 (2) in paragraph (2)(B)(iii), by striking the sec-
5 ond and third sentences and inserting the following:
6 ''The United States may recover under this clause
7 the full amount of the conditional payments made
8 under this title for which an entity is required or re-
9 sponsible to make payment, except that the United
10 States may recover double that amount where the
11 conditional payments were made for items or serv-
12 ices provided as a result of an intentional tort or
13 other intentional wrongdoing. In addition, the
14 United States may recover under this clause from
15 any entity that has received payment from a primary
16 plan or from the proceeds of a primary plan's pay-
17 ment to any entity. An action under this clause or
18 under paragraph (3)(A) may not be brought more
19 than six years after a conditional payment has been
20 made under this title. The United States may join
21 or intervene in any action related to the events that
22 gave rise to the need for the item or service or in
23 any action brought under paragraph (3)(A).''; and
24 (3) by amending subparagraph (A) of para-
25 graph (3) to read as follows:

1 "(A) PRIVATE RIGHT OF ACTION.—

2 "(i) Any person may bring an action
3 for the person and for the United States
4 against any and all entities against which
5 the United States may bring an action as
6 provided in, and in the same manner as set
7 forth in, clause (iii) or (iv) of subpara-
8 graph (B) to recover the full amount of the
9 conditional payments made under this title
10 for which an entity is required or respon-
11 sible to make payment, except that person
12 may recover double that amount where the
13 conditional payments were made for items
14 or services provided as a result of an inten-
15 tional tort or other intentional wrongdoing.

16 "(ii) No action may be brought under
17 this subparagraph based on claims that are
18 the subject of a pending action brought by
19 the United States under clause (iii) of sub-
20 paragraph (B). When a person brings an
21 action under this subparagraph, no person
22 other than the United States may inter-
23 vene or bring a related action based on the
24 facts underlying the pending action.

1 "(iii) In addition to the recovery
2 awarded under this subparagraph (whether
3 that recovery is equal to or double the
4 amount of conditional payments made
5 under this title), the court shall award the
6 person bringing an action under this sub-
7 paragraph an amount equal to 30 percent
8 of that recovery, except as provided in
9 clause (v), plus the actual costs that per-
10 son incurred to prosecute the action.
11 "(iv) The Administrator of the Cen-
12 ters for Medicare & Medicaid Services shall
13 make available to a person who has
14 brought an action under this subpara-
15 graph, upon that person's request, all rea-
16 sonably available data files routinely main-
17 tained by the Centers for Medicare & Med-
18 icaid Services containing encounter-level
19 information with regard to diagnoses,
20 treatments, and costs, including the Stand-
21 ard Analytic Files, the Medicare Provider
22 Analysis and Review files, denominator
23 files, and the Medicare Current Beneficiary
24 Survey files, and any other relevant infor-
25 mation, relating to the payments made

1 under this title that are sought to be recov-
2 ered in that action. The Administrator
3 shall charge such person the reasonable
4 costs of producing this information, except
5 that the Administrator may waive, in whole
6 or in part, such payment by the person
7 bringing the action. The Administrator
8 shall make this information available to
9 that person reasonably promptly after that
10 person has paid that charge. If, by the
11 conclusion of the action, the actual costs of
12 producing this information exceed that
13 charge, that person shall promptly pay the
14 difference to the Administrator. If, by the
15 conclusion of the action, that charge ex-
16 ceeds the actual costs of producing this in-
17 formation, the Administrator shall prompt-
18 ly refund the difference to that person.
19 The actual costs of producing this informa-
20 tion shall be part of the expenses of the ac-
21 tion and shall be awarded to that person
22 (or to the Administrator to the extent the
23 Administrator has waived payment by that
24 person) upon successful completion of the
25 action in addition to the damages other-

1 wise recovered. Notwithstanding section
2 3302 of title 31, United States Code, any
3 payment for the costs of producing data
4 received under this clause shall be credited
5 to the account in the Treasury from which
6 the expenses were incurred and shall be
7 available to the Secretary for those ex-
8 penses, and shall remain available until ex-
9 pended.

10 "(v) If the United States intervenes in
11 the action, it will jointly prosecute the ac-
12 tion with the person who initiated the ac-
13 tion. In such a jointly prosecuted action,
14 the person who initiated the action shall
15 receive at least 20 percent, but no more
16 than 30 percent, of the recovery depending
17 upon the extent to which the person sub-
18 stantially contributed to the prosecution of
19 the action, as determined by the court,
20 plus the reasonable expenses that person
21 incurred to prosecute the action. Upon a
22 showing by the United States or the per-
23 son initiating the action that such joint
24 prosecution would interfere with prompt
25 recovery of payments as provided in this

1 title, the court may, in its discretion, es-
2 tablish the terms under which the United
3 States and the person initiating the action
4 shall prosecute the action. The action may
5 be settled notwithstanding the objections of
6 the United States or the person initiating
7 the action if the court determines, after a
8 hearing, that the proposed settlement, or a
9 modified version of the proposed settle-
10 ment, is fair, adequate, and reasonable
11 under all the circumstances.
12 ''(vi) If the parties to an action
13 brought under this subparagraph in which
14 the United States has not intervened pro-
15 pose to settle the case, the person who ini-
16 tiated the action shall submit to the Attor-
17 ney General and to the Administrator a
18 document setting out all the terms of the
19 proposed settlement and a summary of the
20 reasons for the settlement. No final judg-
21 ment terminating the case based on the
22 terms of the proposed settlement may be
23 entered until 30 days after this document
24 has been received by the Attorney General
25 and by the Administrator. The United

1 States may intervene in the action within
2 that 30-day period to present to the court
3 any objections to the settlement it may
4 have. The action may be settled notwith-
5 standing the objections of the United
6 States if the court determines, after a
7 hearing, that the proposed settlement, or a
8 modified version of the proposed settle-
9 ment, is fair, adequate, and reasonable
10 under all the circumstances.''.

11 Subtitle C—Enhanced Program 12 and Provider Protections

13 SEC. 1631. ENHANCED CMS PROGRAM PROTECTION AU- 14 THORITY.

15 (a) IN GENERAL.—Title XI of the Social Security Act
16 (42 U.S.C. 1301 et seq.) is amended by inserting after
17 section 1128F the following new section:

18 ''SEC. 1128G. ENHANCED PROGRAM AND PROVIDER PRO- 19 TECTIONS IN THE MEDICARE, MEDICAID, AND 20 CHIP PROGRAMS.

21 ''(a) CERTAIN AUTHORIZED SCREENING, ENHANCED
22 OVERSIGHT PERIODS, AND ENROLLMENT MORATORIA.—
23 ''(1) IN GENERAL.—For periods beginning after
24 January 1, 2011, in the case that the Secretary de-
25 termines there is a significant risk of fraudulent ac-

1 tivity (as determined by the Secretary based on rel-
2 evant complaints, reports, referrals by law enforce-
3 ment or other sources, data analysis, trending infor-
4 mation, or claims submissions by providers of serv-
5 ices and suppliers) with respect to a category of pro-
6 vider of services or supplier of items or services, in-
7 cluding a category within a geographic area, under
8 title XVIII, XIX, or XXI, the Secretary may impose
9 any of the following requirements with respect to a
10 provider of services or a supplier (whether such pro-
11 vider or supplier is initially enrolling in the program
12 or is renewing such enrollment):
13 ''(A) Screening under paragraph (2).
14 ''(B) Enhanced oversight periods under
15 paragraph (3).
16 ''(C) Enrollment moratoria under para-
17 graph (4).
18 In applying this subsection for purposes of title XIX
19 and XXI the Secretary may require a State to carry
20 out the provisions of this subsection as a require-
21 ment of the State plan under title XIX or the child
22 health plan under title XXI. Actions taken and de-
23 terminations made under this subsection shall not be
24 subject to review by a judicial tribunal.

1 "(2) SCREENING.—For purposes of paragraph
2 (1), the Secretary shall establish procedures under
3 which screening is conducted with respect to pro-
4 viders of services and suppliers described in such
5 paragraph. Such screening may include—
6 "(A) licensing board checks;
7 "(B) screening against the list of individ-
8 uals and entities excluded from the program
9 under title XVIII, XIX, or XXI;
10 "(C) the excluded provider list system;
11 "(D) background checks; and
12 "(E) unannounced pre-enrollment or other
13 site visits.
14 "(3) ENHANCED OVERSIGHT PERIOD.—For
15 purposes of paragraph (1), the Secretary shall estab-
16 lish procedures to provide for a period of not less
17 than 30 days and not more than 365 days during
18 which providers of services and suppliers described
19 in such paragraph, as the Secretary determines ap-
20 propriate, would be subject to enhanced oversight,
21 such as required or unannounced (or required and
22 unannounced) site visits or inspections, prepayment
23 review, enhanced review of claims, and such other
24 actions as specified by the Secretary, under the pro-
25 grams under titles XVIII, XIX, and XXI. Under

1 such procedures, the Secretary may extend such pe-
2 riod for more than 365 days if the Secretary deter-
3 mines that after the initial period such additional
4 period of oversight is necessary.

5 "(4) MORATORIUM ON ENROLLMENT OF PRO-
6 VIDERS AND SUPPLIERS.—For purposes of para-
7 graph (1), the Secretary, based upon a finding of a
8 risk of serious ongoing fraud within a program
9 under title XVIII, XIX, or XXI, may impose a mor-
10 atorium on the enrollment of providers of services
11 and suppliers within a category of providers of serv-
12 ices and suppliers (including a category within a spe-
13 cific geographic area) under such title. Such a mora-
14 torium may only be imposed if the Secretary makes
15 a determination that the moratorium would not ad-
16 versely impact access of individuals to care under
17 such program.

18 "(5) CLARIFICATION.—Nothing in this sub-
19 section shall be interpreted to preclude or limit the
20 ability of a State to engage in provider screening or
21 enhanced provider oversight activities beyond those
22 required by the Secretary.".

23 (b) CONFORMING AMENDMENTS.—

1 (1) MEDICAID.—Section 1902(a) of the Social
2 Security Act (42 U.S.C. 42 U.S.C. 1396a(a)) is
3 amended—
4 (A) in paragraph (23), by inserting before
5 the semicolon at the end the following: ''or by
6 a person to whom or entity to which a morato-
7 rium under section 1128G(a)(4) is applied dur-
8 ing the period of such moratorium'';
9 (B) in paragraph (72); by striking at the
10 end ''and'';
11 (C) in paragraph (73), by striking the pe-
12 riod at the end and inserting ''and''; and
13 (D) by adding after paragraph (73) the
14 following new paragraph:
15 ''(74) provide that the State will enforce any
16 determination made by the Secretary under sub-
17 section (a) of section 1128G (relating to a signifi-
18 cant risk of fraudulent activity with respect to a cat-
19 egory of provider or supplier described in such sub-
20 section (a) through use of the appropriate proce-
21 dures described in such subsection (a)), and that the
22 State will carry out any activities as required by the
23 Secretary for purposes of such subsection (a).''.

1 (2) CHIP.—Section 2102 of such Act (42
2 U.S.C. 1397bb) is amended by adding at the end the
3 following new subsection:
4 "(d) PROGRAM INTEGRITY.—A State child health
5 plan shall include a description of the procedures to be
6 used by the State—
7 "(1) to enforce any determination made by the
8 Secretary under subsection (a) of section 1128G (re-
9 lating to a significant risk of fraudulent activity with
10 respect to a category of provider or supplier de-
11 scribed in such subsection through use of the appro-
12 priate procedures described in such subsection); and
13 "(2) to carry out any activities as required by
14 the Secretary for purposes of such subsection.".
15 (3) MEDICARE.—Section 1866(j) of such Act
16 (42 U.S.C. 1395cc(j)) is amended by adding at the
17 end the following new paragraph:
18 "(3) PROGRAM INTEGRITY.—The provisions of
19 section 1128G(a) apply to enrollments and renewals
20 of enrollments of providers of services and suppliers
21 under this title.".

1 **SEC. 1632. ENHANCED MEDICARE, MEDICAID, AND CHIP**
2 **PROGRAM DISCLOSURE REQUIREMENTS RE-**
3 **LATING TO PREVIOUS AFFILIATIONS.**

4 (a) IN GENERAL.—Section 1128G of the Social Secu-
5 rity Act, as inserted by section 1631, is amended by add-
6 ing at the end the following new subsection:
7 "(b) ENHANCED PROGRAM DISCLOSURE REQUIRE-
8 MENTS.—
9 "(1) DISCLOSURE.—A provider of services or
10 supplier who submits on or after July 1, 2011, an
11 application for enrollment and renewing enrollment
12 in a program under title XVIII, XIX, or XXI shall
13 disclose (in a form and manner determined by the
14 Secretary) any current affiliation or affiliation with-
15 in the previous 10-year period with a provider of
16 services or supplier that has uncollected debt or with
17 a person or entity that has been suspended or ex-
18 cluded under such program, subject to a payment
19 suspension, or has had its billing privileges revoked.
20 "(2) ENHANCED SAFEGUARDS.—If the Sec-
21 retary determines that such previous affiliation of
22 such provider or supplier poses a risk of fraud,
23 waste, or abuse, the Secretary may apply such en-
24 hanced safeguards as the Secretary determines nec-
25 essary to reduce such risk associated with such pro-
26 vider or supplier enrolling or participating in the

1 program under title XVIII, XIX, or XXI. Such safe-
2 guards may include enhanced oversight, such as en-
3 hanced screening of claims, required or unannounced
4 (or required and unannounced) site visits or inspec-
5 tions, additional information reporting requirements,
6 and conditioning such enrollment on the provision of
7 a surety bond.

8 ''(3) AUTHORITY TO DENY PARTICIPATION.—If
9 the Secretary determines that there has been at
10 least one such affiliation and that such affiliation or
11 affiliations, as applicable, of such provider or sup-
12 plier poses a serious risk of fraud, waste, or abuse,
13 the Secretary may deny the application of such pro-
14 vider or supplier.''.

15 (b) CONFORMING AMENDMENTS.—

16 (1) MEDICAID.—Paragraph (74) of section
17 1902(a) of such Act (42 U.S.C. 1396a(a)), as added
18 by section 1631(b)(1), is amended—

19 (A) by inserting ''or subsection (b) of such
20 section (relating to disclosure requirements)''
21 before '', and that the State''; and

22 (B) by inserting before the period the fol-
23 lowing: ''and apply any enhanced safeguards,
24 with respect to a provider or supplier described

1 in such subsection (b), as the Secretary deter-
2 mines necessary under such subsection (b)''.
3 (2) CHIP.—Subsection (d) of section 2102 of
4 such Act (42 U.S.C. 1397bb), as added by section
5 1631(b)(2), is amended—
6 (A) in paragraph (1), by striking at the
7 end ''and'';
8 (B) in paragraph (2) by striking the period
9 at the end and inserting ''; and' '' and
10 (C) by adding at the end the following new
11 paragraph:
12 ''(3) to enforce any determination made by the
13 Secretary under subsection (b) of section 1128G (re-
14 lating to disclosure requirements) and to apply any
15 enhanced safeguards, with respect to a provider or
16 supplier described in such subsection, as the Sec-
17 retary determines necessary under such subsection.''.

18 **SEC. 1633. REQUIRED INCLUSION OF PAYMENT MODIFIER**
19 **FOR CERTAIN EVALUATION AND MANAGE-**
20 **MENT SERVICES.**

21 Section 1848 of the Social Security Act (42 U.S.C.
22 1395w–4), as amended by section 4101 of the HITECH
23 Act (Public Law 111–5), is amended by adding at the end
24 the following new subsection:

1 "(p) PAYMENT MODIFIER FOR CERTAIN EVALUA-
2 TION AND MANAGEMENT SERVICES.—The Secretary shall
3 establish a payment modifier under the fee schedule under
4 this section for evaluation and management services (as
5 specified in section 1842(b)(16)(B)(ii)) that result in the
6 ordering of additional services (such as lab tests), the pre-
7 scription of drugs, the furnishing or ordering of durable
8 medical equipment in order to enable better monitoring
9 of claims for payment for such additional services under
10 this title, or the ordering, furnishing, or prescribing of
11 other items and services determined by the Secretary to
12 pose a high risk of waste, fraud, and abuse. The Secretary
13 may require providers of services or suppliers to report
14 such modifier in claims submitted for payment.".

15 **SEC. 1634. EVALUATIONS AND REPORTS REQUIRED UNDER**
16 **MEDICARE INTEGRITY PROGRAM.**

17 (a) IN GENERAL.—Section 1893(c) of the Social Se-
18 curity Act (42 U.S.C. 1395ddd(c)) is amended—
19 (1) in paragraph (3), by striking at the end
20 "and";
21 (2) by redesignating paragraph (4) as para-
22 graph (5); and
23 (3) by inserting after paragraph (3) the fol-
24 lowing new paragraph:

1 "(4) for the contract year beginning in 2011
2 and each subsequent contract year, the entity pro-
3 vides assurances to the satisfaction of the Secretary
4 that the entity will conduct periodic evaluations of
5 the effectiveness of the activities carried out by such
6 entity under the Program and will submit to the
7 Secretary an annual report on such activities; and".
8 (b) REFERENCE TO MEDICAID INTEGRITY PRO-
9 GRAM.—For a similar provision with respect to the Med-
10 icaid Integrity Program, see section 1752.

11 **SEC. 1635. REQUIRE PROVIDERS AND SUPPLIERS TO**
12 **ADOPT PROGRAMS TO REDUCE WASTE,**
13 **FRAUD, AND ABUSE.**

14 (a) IN GENERAL.—Section 1874 of the Social Secu-
15 rity Act (42 U.S.C. 42 U.S.C. 1395kk) is amended by
16 adding at the end the following new subsection:
17 "(d) COMPLIANCE PROGRAMS FOR PROVIDERS OF
18 SERVICES AND SUPPLIERS.—
19 "(1) IN GENERAL.—The Secretary may
20 disenroll a provider of services or a supplier (other
21 than a physician or a skilled nursing facility) under
22 this title (or may impose any civil monetary penalty
23 or other intermediate sanction under paragraph (4))
24 if such provider of services or supplier fails to, sub-
25 ject to paragraph (5), establish a compliance pro-

1 gram that contains the core elements established
2 under paragraph (2).
3 "(2) ESTABLISHMENT OF CORE ELEMENTS.—
4 The Secretary, in consultation with the Inspector
5 General of the Department of Health and Human
6 Services, shall establish core elements for a compli-
7 ance program under paragraph (1). Such elements
8 may include written policies, procedures, and stand-
9 ards of conduct, a designated compliance officer and
10 a compliance committee; effective training and edu-
11 cation pertaining to fraud, waste, and abuse for the
12 organization's employees and contractors; a con-
13 fidential or anonymous mechanism, such as a hot-
14 line, to receive compliance questions and reports of
15 fraud, waste, or abuse; disciplinary guidelines for en-
16 forcement of standards; internal monitoring and au-
17 diting procedures, including monitoring and auditing
18 of contractors; procedures for ensuring prompt re-
19 sponses to detected offenses and development of cor-
20 rective action initiatives, including responses to po-
21 tential offenses; and procedures to return all identi-
22 fied overpayments to the programs under this title,
23 title XIX, and title XXI.
24 "(3) TIMELINE FOR IMPLEMENTATION.—The
25 Secretary shall determine a timeline for the estab-

1 lishment of the core elements under paragraph (2)
2 and the date on which a provider of services and
3 suppliers (other than physicians) shall be required to
4 have established such a program for purposes of this
5 subsection.

6 "(4) CMS ENFORCEMENT AUTHORITY.—The
7 Administrator for the Centers of Medicare & Med-
8 icaid Services shall have the authority to determine
9 whether a provider of services or supplier described
10 in subparagraph (3) has met the requirement of this
11 subsection and to impose a civil monetary penalty
12 not to exceed $50,000 for each violation. The Sec-
13 retary may also impose other intermediate sanctions,
14 including corrective action plans and additional mon-
15 itoring in the case of a violation of this subsection.

16 "(5) PILOT PROGRAM.—The Secretary may
17 conduct a pilot program on the application of this
18 subsection with respect to a category of providers of
19 services or suppliers (other than physicians) that the
20 Secretary determines to be a category which is at
21 high risk for waste, fraud, and abuse before imple-
22 menting the requirements of this subsection to all
23 providers of services and suppliers described in para-
24 graph (3).".

1 (b) REFERENCE TO SIMILAR MEDICAID PROVI-
2 SION.—For a similar provision with respect to the Med-
3 icaid program under title XIX of the Social Security Act,
4 see section 1753.

5 **SEC. 1636. MAXIMUM PERIOD FOR SUBMISSION OF MEDI-**
6 **CARE CLAIMS REDUCED TO NOT MORE THAN**
7 **12 MONTHS.**

8 (a) PURPOSE.—In general, the 36-month period cur-
9 rently allowed for claims filing under parts A, B, C, and,
10 D of title XVIII of the Social Security Act presents oppor-
11 tunities for fraud schemes in which processing patterns
12 of the Centers for Medicare & Medicaid Services can be
13 observed and exploited. Narrowing the window for claims
14 processing will not overburden providers and will reduce
15 fraud and abuse.

16 (b) REDUCING MAXIMUM PERIOD FOR SUBMIS-
17 SION.—

18 (1) PART A.—Section 1814(a) of the Social Se-
19 curity Act (42 U.S.C. 1395f(a)) is amended—

20 (A) in paragraph (1), by strikeing ''period
21 of 3 calendar years'' and all that follows and in-
22 serting ''period of 1 calendar year from which
23 such services are furnished; and''; and

24 (B) by adding at the end the following new
25 sentence: ''In applying paragraph (1), the Sec-

1 retary may specify exceptions to the 1 calendar
2 year period specified in such paragraph.''.
3 (2) PART B.—Section 1835(a) of such Act (42
4 U.S.C. 1395n(a)) is amended—
5 (A) in paragraph (1), by strikeing ''period
6 of 3 calendar years'' and all that follows and in-
7 serting ''period of 1 calendar year from which
8 such services are furnished; and''; and
9 (B) by adding at the end the following new
10 sentence: ''In applying paragraph (1), the Sec-
11 retary may specify exceptions to the 1 calendar
12 year period specified in such paragraph.''.
13 (3) PARTS C AND D.—Section 1857(d) of such
14 Act is amended by adding at the end the following
15 new paragraph:
16 ''(7) PERIOD FOR SUBMISSION OF CLAIMS.—
17 The contract shall require an MA organization or
18 PDP sponsor to require any provider of services
19 under contract with, in partnership with, or affili-
20 ated with such organization or sponsor to ensure
21 that, with respect to items and services furnished by
22 such provider to an enrollee of such organization,
23 written request, signed by such enrollee, except in
24 cases in which the Secretary finds it impracticable
25 for the enrollee to do so, is filed for payment for

1 such items and services in such form, in such man-
2 ner, and by such person or persons as the Secretary
3 may by regulation prescribe, no later than the close
4 of the 1 calendar year period after such items and
5 services are furnished. In applying the previous sen-
6 tence, the Secretary may specify exceptions to the 1
7 calendar year period specified.''.
8 (c) EFFECTIVE DATE.—The amendments made by
9 subsection (b) shall be effective for items and services fur-
10 nished on or after January 1, 2011.

11 **SEC. 1637. PHYSICIANS WHO ORDER DURABLE MEDICAL**
12 **EQUIPMENT OR HOME HEALTH SERVICES RE-**
13 **QUIRED TO BE MEDICARE ENROLLED PHYSI-**
14 **CIANS OR ELIGIBLE PROFESSIONALS.**

15 (a) DME.—Section 1834(a)(11)(B) of the Social Se-
16 curity Act (42 U.S.C. 1395m(a)(11)(B)) is amended by
17 striking ''physician'' and inserting ''physician enrolled
18 under section 1866(j) or an eligible professional under sec-
19 tion 1848(k)(3)(B)''.
20 (b) HOME HEALTH SERVICES.—
21 (1) PART A.—Section 1814(a)(2) of such Act
22 (42 U.S.C. 1395(a)(2)) is amended in the matter
23 preceding subparagraph (A) by inserting ''in the
24 case of services described in subparagraph (C), a
25 physician enrolled under section 1866(j) or an eligi-

1 ble professional under section 1848(k)(3)(B),'' be-
2 fore ''or, in the case of services''.
3 (2) PART B.—Section 1835(a)(2) of such Act
4 (42 U.S.C. 1395n(a)(2)) is amended in the matter
5 preceding subparagraph (A) by inserting '', or in the
6 case of services described in subparagraph (A), a
7 physician enrolled under section 1866(j) or an eligi-
8 ble professional under section 1848(k)(3)(B),'' after
9 ''a physician''.
10 (c) DISCRETION TO EXPAND APPLICATION.—The
11 Secretary may extend the requirement applied by the
12 amendments made by subsections (a) and (b) to durable
13 medical equipment and home health services (relating to
14 requiring certifications and written orders to be made by
15 enrolled physicians and health professions) to other cat-
16 egories of items or services under this title, including cov-
17 ered part D drugs as defined in section 1860D–2(e), if
18 the Secretary determines that such application would help
19 to reduce the risk of waste, fraud, and abuse with respect
20 to such other categories under title XVIII of the Social
21 Security Act.
22 (d) EFFECTIVE DATE.—The amendments made by
23 this section shall apply to written orders and certifications
24 made on or after July 1, 2010.

1 **SEC. 1638. REQUIREMENT FOR PHYSICIANS TO PROVIDE**
2 **DOCUMENTATION ON REFERRALS TO PRO-**
3 **GRAMS AT HIGH RISK OF WASTE AND ABUSE.**

4 (a) PHYSICIANS AND OTHER SUPPLIERS.—Section
5 1842(h) of the Social Security Act, as amended by section
6 1635, is further amended by adding at the end the fol-
7 lowing new paragraph

8 "(10) The Secretary may disenroll, for a period of
9 not more than one year for each act, a physician or sup-
10 plier under section 1866(j) if such physician or supplier
11 fails to maintain and, upon request of the Secretary, pro-
12 vide access to documentation relating to written orders or
13 requests for payment for durable medical equipment, cer-
14 tifications for home health services, or referrals for other
15 items or services written or ordered by such physician or
16 supplier under this title, as specified by the Secretary.".

17 (b) PROVIDERS OF SERVICES.—Section 1866(a)(1)
18 of such Act (42 U.S.C. 1395cc), as amended by section
19 1635, is further amended—

20 (1) in subparagraph (V), by striking at the end
21 "and";

22 (2) in subparagraph (W), by striking the period
23 at the end and adding "; and"; and

24 (3) by adding at the end the following new sub-
25 paragraph:

1 "(X) maintain and, upon request of the
2 Secretary, provide access to documentation re-
3 lating to written orders or requests for payment
4 for durable medical equipment, certifications for
5 home health services, or referrals for other
6 items or services written or ordered by the pro-
7 vider under this title, as specified by the Sec-
8 retary.".

9 (c) OIG PERMISSIVE EXCLUSION AUTHORITY.—Sec-
10 tion 1128(b)(11) of the Social Security Act (42 U.S.C.
11 1320a–7(b)(11)) is amended by inserting ", ordering, re-
12 ferring for furnishing, or certifying the need for" after
13 "furnishing".

14 (d) EFFECTIVE DATE.—The amendments made by
15 this section shall apply to orders, certifications, and refer-
16 rals made on or after January 1, 2010.

17 **SEC. 1639. FACE TO FACE ENCOUNTER WITH PATIENT RE-**
18 **QUIRED BEFORE PHYSICIANS MAY CERTIFY**
19 **ELIGIBILITY FOR HOME HEALTH SERVICES**
20 **OR DURABLE MEDICAL EQUIPMENT UNDER**
21 **MEDICARE.**

22 (a) CONDITION OF PAYMENT FOR HOME HEALTH
23 SERVICES.—

24 (1) PART A.—Section 1814(a)(2)(C) of such
25 Act is amended—

1 (A) by striking ‘‘and such services’’ and in-
2 serting ‘‘such services’’; and
3 (B) by inserting after ‘‘care of a physi-
4 cian’’ the following: ‘‘, and, in the case of a cer-
5 tification or recertification made by a physician
6 after January 1, 2010, prior to making such
7 certification the physician must document that
8 the physician has had a face-to-face encounter
9 (including through use of telehealth and other
10 than with respect to encounters that are inci-
11 dent to services involved) with the individual
12 during the 6-month period preceding such cer-
13 tification, or other reasonable timeframe as de-
14 termined by the Secretary’’.
15 (2) PART B.—Section 1835(a)(2)(A) of the So-
16 cial Security Act is amended—
17 (A) by striking ‘‘and’’ before ‘‘(iii)’’; and
18 (B) by inserting after ‘‘care of a physi-
19 cian’’ the following: ‘‘, and (iv) in the case of
20 a certification or recertification after January
21 1, 2010, prior to making such certification the
22 physician must document that the physician has
23 had a face-to-face encounter (including through
24 use of telehealth and other than with respect to
25 encounters that are incident to services in-

1 volved) with the individual during the 6-month
2 period preceding such certification or recertifi-
3 cation, or other reasonable timeframe as deter-
4 mined by the Secretary''.

5 (b) CONDITION OF PAYMENT FOR DURABLE MED-
6 ICAL EQUIPMENT.—Section 1834(a)(11)(B) of the Social
7 Security Act (42 U.S.C. 1395m(a)(11)(B)) is amended by
8 adding at the end the following: ''and shall require that
9 such an order be written pursuant to the physician docu-
10 menting that the physician has had a face-to-face encoun-
11 ter (including through use of telehealth and other than
12 with respect to encounters that are incident to services in-
13 volved) with the individual involved during the 6-month
14 period preceding such written order, or other reasonable
15 timeframe as determined by the Secretary''.

16 (c) APPLICATION TO OTHER AREAS UNDER MEDI-
17 CARE.—The Secretary may apply the face-to-face encoun-
18 ter requirement described in the amendments made by
19 subsections (a) and (b) to other items and services for
20 which payment is provided under title XVIII of the Social
21 Security Act based upon a finding that such an decision
22 would reduce the risk of waste, fraud, or abuse.

23 (d) APPLICATION TO MEDICAID AND CHIP.—The re-
24 quirements pursuant to the amendments made by sub-
25 sections (a) and (b) shall apply in the case of physicians

1 making certifications for home health services under title
2 XIX or XXI of the Social Security Act, in the same man-
3 ner and to the same extent as such requirements apply
4 in the case of physicians making such certifications under
5 title XVIII of such Act.

6 **SEC. 1640. EXTENSION OF TESTIMONIAL SUBPOENA AU-**
7 **THORITY TO PROGRAM EXCLUSION INVES-**
8 **TIGATIONS.**

9 (a) IN GENERAL.—Section 1128(f) of the Social Se-
10 curity Act (42 U.S.C. 1320a-7(f)) is amended by adding
11 at the end the following new paragraph:

12 ''(4) The provisions of subsections (d) and (e) of sec-
13 tion 205 shall apply with respect to this section to the
14 same extent as they are applicable with respect to title
15 II. The Secretary may delegate the authority granted by
16 section 205(d) (as made applicable to this section) to the
17 Inspector General of the Department of Health and
18 Human Services or the Administrator of the Centers for
19 Medicare & Medicaid Services for purposes of any inves-
20 tigation under this section.''.

21 (b) EFFECTIVE DATE.—The amendment made by
22 subsection (a) shall apply to investigations beginning on
23 or after January 1, 2010.

1 **SEC. 1641. REQUIRED REPAYMENTS OF MEDICARE AND**
2 **MEDICAID OVERPAYMENTS.**

3 Section 1128G of the Social Security Act, as inserted
4 by section 1631 and amended by section 1632, is further
5 amended by adding at the end the following new sub-
6 section:

7 "(c) REPORTS ON AND REPAYMENT OF OVERPAY-
8 MENTS IDENTIFIED THROUGH INTERNAL AUDITS AND
9 REVIEWS.—

10 "(1) REPORTING AND RETURNING OVERPAY-
11 MENTS.—If a person knows of an overpayment, the
12 person must—

13 "(A) report and return the overpayment to
14 the Secretary, the State, an intermediary, a
15 carrier, or a contractor, as appropriate, at the
16 correct address, and

17 "(B) notify the Secretary, the State, inter-
18 mediary, carrier, or contractor to whom the
19 overpayment was returned in writing of the rea-
20 son for the overpayment.

21 "(2) TIMING.—An overpayment must be re-
22 ported and returned under paragraph (1)(A) by not
23 later than the date that is 60 days after the date the
24 person knows of the overpayment.

25 Any known overpayment retained later than the ap-
26 plicable date specified in this paragraph creates an

1 obligation as defined in section 3729(b)(3) of title
2 31 of the United States Code.
3 ‘‘(3) CLARIFICATION.—Repayment of any over-
4 payments (or refunding by withholding of future
5 payments) by a provider of services or supplier does
6 not otherwise limit the provider or supplier’s poten-
7 tial liability for administrative obligations such as
8 applicable interests, fines, and specialties or civil or
9 criminal sanctions involving the same claim if it is
10 determined later that the reason for the overpay-
11 ment was related to fraud by the provider or sup-
12 plier or the employees or agents of such provider or
13 supplier.
14 ‘‘(4) DEFINITIONS.—In this subsection:
15 ‘‘(A) KNOWS.—The term ‘knows’ has the
16 meaning given the terms ‘knowing’ and ‘know-
17 ingly’ in section 3729(b) of title 31 of the
18 United States Code.
19 ‘‘(B) OVERPAYMENT.—The term ‘‘overpay-
20 ment’’ means any finally determined funds that
21 a person receives or retains under title XVIII,
22 XIX, or XXI to which the person, after applica-
23 ble reconciliation, is not entitled under such
24 title.

1 "(C) PERSON.—The term 'person' means a
2 provider of services, supplier, Medicaid man-
3 aged care organization (as defined in section
4 1903(m)(1)(A)), Medicare Advantage organiza-
5 tion (as defined in section 1859(a)(1)), or PDP
6 sponsor (as defined in section 1860D–
7 41(a)(13)), but excluding a beneficiary.".

8 **SEC. 1642. EXPANDED APPLICATION OF HARDSHIP WAIV-**
9 **ERS FOR OIG EXCLUSIONS TO BENE-**
10 **FICIARIES OF ANY FEDERAL HEALTH CARE**
11 **PROGRAM.**

12 Section 1128(c)(3)(B) of the Social Security Act (42
13 U.S.C. 1320a–7(c)(3)(B)) is amended by striking "indi-
14 viduals entitled to benefits under part A of title XVIII
15 or enrolled under part B of such title, or both" and insert-
16 ing "beneficiaries (as defined in section 1128A(i)(5)) of
17 that program".

18 **SEC. 1643. ACCESS TO CERTAIN INFORMATION ON RENAL**
19 **DIALYSIS FACILITIES.**

20 Section 1881(b) of the Social Security Act (42 U.S.C.
21 1395rr(b)) is amended by adding at the end the following
22 new paragraph:

23 "(15) For purposes of evaluating or auditing pay-
24 ments made to renal dialysis facilities for items and serv-
25 ices under this section under paragraph (1), each such

1 renal dialysis facility, upon the request of the Secretary,
2 shall provide to the Secretary access to information relat-
3 ing to any ownership or compensation arrangement be-
4 tween such facility and the medical director of such facility
5 or between such facility and any physician.''.

6 **SEC. 1644. BILLING AGENTS, CLEARINGHOUSES, OR OTHER**
7 **ALTERNATE PAYEES REQUIRED TO REG-**
8 **ISTER UNDER MEDICARE.**

9 (a) MEDICARE.—Section 1866(j)(1) of the Social Se-
10 curity Act (42 U.S.C. 1395cc(j)(1)) is amended by adding
11 at the end the following new subparagraph:

12 ''(D) BILLING AGENTS AND CLEARING-
13 HOUSES REQUIRED TO BE REGISTER UNDER
14 MEDICARE.—Any agent, clearinghouse, or other
15 alternate payee that submits claims on behalf of
16 a health care provider must be registered with
17 the Secretary in a form and manner specified
18 by the Secretary.''.

19 (b) MEDICAID.—For a similar provision with respect
20 to the Medicaid program under title XIX of the Social Se-
21 curity Act, see section 1759.

22 (c) EFFECTIVE DATE.—The amendment made by
23 subsection (a) shall apply to claims submitted on or after
24 January 1, 2012.

1 **SEC. 1645. CONFORMING CIVIL MONETARY PENALTIES TO**
2 **FALSE CLAIMS ACT AMENDMENTS.**

3 Section 1128A of the Social Security Act, as amended
4 by sections 1611, 1612, 1613, and 1615, is further
5 amended—
6 (1) in subsection (a)—
7 (A) in paragraph (1), by striking ‘‘to an
8 officer, employee, or agent of the United States,
9 or of any department or agency thereof, or of
10 any State agency (as defined in subsection
11 (i)(1))’’;
12 (B) in paragraph (4)—
13 (i) by striking ‘‘participating in a pro-
14 gram under title XVIII or a State health
15 care program’’ and inserting ‘‘participating
16 in a Federal health care program (as de-
17 fined in section 1128B(f))’’; and
18 (ii) in subparagraph (A), by striking
19 ‘‘title XVIII or a State health care pro-
20 gram’’ and inserting ‘‘a Federal health
21 care program (as defined in section
22 1128B(f))’’;
23 (C) by striking ‘‘or’’ at the end of para-
24 graph (10);
25 (D) by inserting after paragraph (11) the
26 following new paragraphs:

1 "(12) conspires to commit a violation of this
2 section; or
3 "(13) knowingly makes, uses, or causes to be
4 made or used, a false record or statement material
5 to an obligation to pay or transmit money or prop-
6 erty to a Federal health care program, or knowingly
7 conceals or knowingly and improperly avoids or de-
8 creases an obligation to pay or transmit money or
9 property to a Federal health care program;"; and
10 (E) in the matter following paragraph
11 (13), as inserted by subparagraph (D), by strik-
12 ing "or in cases under paragraph (11), $50,000
13 for each such violation" and inserting "in cases
14 under paragraph (11), $50,000 for each such
15 violation, in cases under paragraph (12),
16 $50,000 for any violation described in this sec-
17 tion committed in furtherance of the conspiracy
18 involved; or in cases under paragraph (13),
19 $50,000 for each false record or statement, or
20 concealment, avoidance, or decrease"; and
21 (F) in the second sentence, by striking
22 "such false statement or misrepresentation)"
23 and inserting "such false statement or mis-
24 representation, in cases under paragraph (12),
25 an assessment of not more than 3 times the

1 total amount that would otherwise apply for
2 any violation described in this section com-
3 mitted in furtherance of the conspiracy in-
4 volved, or in cases under paragraph (13), an as-
5 sessment of not more than 3 times the total
6 amount of the obligation to which the false
7 record or statment was material or that was
8 avoided or decreased)''.

9 (2) in subsection (c)(1), by striking ''six years''
10 and inserting ''10 years''; and

11 (3) in subsection (i)—

12 (A) by amending paragraph (2) to read as
13 follows:

14 ''(2) The term ''claim'' means any application,
15 request, or demand, whether under contract, or oth-
16 erwise, for money or property for items and services
17 under a Federal health care program (as defined in
18 section 1128B(f)), whether or not the United States
19 or a State agency has title to the money or property,
20 that—

21 ''(A) is presented or caused to be pre-
22 sented to an officer, employee, or agent of the
23 United States, or of any department or agency
24 thereof, or of any State agency (as defined in
25 subsection (i)(1)); or

1 "(B) is made to a contractor, grantee, or
2 other recipient if the money or property is to be
3 spent or used on the Federal health care pro-
4 gram's behalf or to advance a Federal health
5 care program interest, and if the Federal health
6 care program—
7 "(i) provides or has provided any por-
8 tion of the money or property requested or
9 demanded; or
10 "(ii) will reimburse such contractor,
11 grantee, or other recipient for any portion
12 of the money or property which is re-
13 quested or demanded.";
14 (B) by amending paragraph (3) to read as
15 follows:
16 "(3) The term 'item or service' means, without
17 limitation, any medical, social, management, admin-
18 istrative, or other item or service used in connection
19 with or directly or indirectly related to a Federal
20 health care program.";
21 (C) in paragraph (6)—
22 (i) in subparagraph (C), by striking at
23 the end "or";

1 (ii) in the first subparagraph (D), by
2 striking at the end the period and inserting
3 "; or"; and
4 (iii) by redesignating the second sub-
5 paragraph (D) as a subparagraph (E);
6 (D) by amending paragraph (7) to read as
7 follows:
8 "(7) The terms 'knowing', 'knowingly', and
9 'should know' mean that a person, with respect to
10 information—
11 "(A) has actual knowledge of the informa-
12 tion;
13 "(B) acts in deliberate ignorance of the
14 truth or falsity of the information; or
15 "(C) acts in reckless disregard of the truth
16 or falsity of the information;
17 and require no proof of specific intent to defraud.";
18 and
19 (E) by adding at the end the following new
20 paragraphs:
21 "(8) The term 'obligation' means an established
22 duty, whether or not fixed, arising from an express
23 or implied contractual, grantor-grantee, or licensor-
24 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

1 claims and payment data relating to titles XVIII and XIX,
2 in consultation with the Centers for Medicare & Medicaid
3 Services or the owner of such data.''.

4 **SEC. 1652. ELIMINATION OF DUPLICATION BETWEEN THE**
5 **HEALTHCARE INTEGRITY AND PROTECTION**
6 **DATA BANK AND THE NATIONAL PRACTI-**
7 **TIONER DATA BANK.**

8 (a) IN GENERAL.—To eliminate duplication between
9 the Healthcare Integrity and Protection Data Bank
10 (HIPDB) established under section 1128E of the Social
11 Security Act and the National Practitioner Data Bank
12 (NPBD) established under the Health Care Quality Im-
13 provement Act of 1986, section 1128E of the Social Secu-
14 rity Act (42 U.S.C. 1320a-7e) is amended—

15 (1) in subsection (a), by striking ''Not later
16 than'' and inserting ''Subject to subsection (h), not
17 later than'';

18 (2) in the first sentence of subsection (d)(2), by
19 striking ''(other than with respect to requests by
20 Federal agencies)''; and

21 (3) by adding at the end the following new sub-
22 section:

23 ''(h) SUNSET OF THE HEALTHCARE INTEGRITY AND
24 PROTECTION DATA BANK; TRANSITION PROCESS.—Ef-
25 fective upon the enactment of this subsection, the Sec-

1 retary shall implement a process to eliminate duplication
2 between the Healthcare Integrity and Protection Data
3 Bank (in this subsection referred to as the 'HIPDB' es-
4 tablished pursuant to subsection (a) and the National
5 Practitioner Data Bank (in this subsection referred to as
6 the 'NPDB') as implemented under the Health Care Qual-
7 ity Improvement Act of 1986 and section 1921 of this Act,
8 including systems testing necessary to ensure that infor-
9 mation formerly collected in the HIPDB will be accessible
10 through the NPDB, and other activities necessary to
11 eliminate duplication between the two data banks. Upon
12 the completion of such process, notwithstanding any other
13 provision of law, the Secretary shall cease the operation
14 of the HIPDB and shall collect information required to
15 be reported under the preceding provisions of this section
16 in the NPDB. Except as otherwise provided in this sub-
17 section, the provisions of subsections (a) through (g) shall
18 continue to apply with respect to the reporting of (or fail-
19 ure to report), access to, and other treatment of the infor-
20 mation specified in this section..''.

21 (b) ELIMINATION OF THE RESPONSIBILITY OF THE
22 HHS OFFICE OF THE INSPECTOR GENERAL.—Section
23 1128C(a)(1) of the Social Security Act (42 U.S.C. 1320a-
24 7c(a)(1)) is amended—

1 (1) in subparagraph (C), by adding at the end
2 ‘‘and’’;
3 (2) in subparagraph (D), by striking at the end
4 ‘‘, and’’ and inserting a period; and
5 (3) by striking subparagraph (E).
6 (c) SPECIAL PROVISION FOR ACCESS TO THE NA-
7 TIONAL PRACTITIONER DATA BANK BY THE DEPART-
8 MENT OF VETERANS AFFAIRS.—
9 (1) IN GENERAL.—Notwithstanding any other
10 provision of law, during the one year period that be-
11 gins on the effective date specified in subsection
12 (e)(1), the information described in paragraph (2)
13 shall be available from the National Practitioner
14 Data Bank (described in section 1921 of the Social
15 Security Act) to the Secretary of Veterans Affairs
16 without charge.
17 (2) INFORMATION DESCRIBED.—For purposes
18 of paragraph (1), the information described in this
19 paragraph is the information that would, but for the
20 amendments made by this section, have been avail-
21 able to the Secretary of Veterans Affairs from the
22 Healthcare Integrity and Protection Data Bank.
23 (d) FUNDING.—Notwithstanding any provisions of
24 this Act, sections 1128E(d)(2) and 1817(k)(3) of the So-
25 cial Security Act, or any other provision of law, there shall

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.

1 **SEC. 1653. COMPLIANCE WITH HIPAA PRIVACY AND SECU-**
2 **RITY STANDARDS.**

3 The provisions of sections 262(a) and 264 of the
4 Health Insurance Portability and Accountability Act of
5 1996 (and standards promulgated pursuant to such sec-
6 tions) and the Privacy Act of 1974 shall apply with respect
7 to the provisions of this subtitle and amendments made
8 by this subtitle.

9 TITLE VII—MEDICAID AND CHIP
10 [*TEXT OMITTED BECAUSE OUT-*
11 *SIDE JURISDICTION OF COM-*
12 *MITTEE ON WAYS AND MEANS*]

13 TITLE VIII—REVENUE-RELATED
14 PROVISIONS

15 **SEC. 1801. DISCLOSURES TO FACILITATE IDENTIFICATION**
16 **OF INDIVIDUALS LIKELY TO BE INELIGIBLE**
17 **FOR THE LOW-INCOME ASSISTANCE UNDER**
18 **THE MEDICARE PRESCRIPTION DRUG PRO-**
19 **GRAM TO ASSIST SOCIAL SECURITY ADMINIS-**
20 **TRATION'S OUTREACH TO ELIGIBLE INDIVID-**
21 **UALS.**

22 (a) IN GENERAL.—Paragraph (19) of section 6103(l)
23 of the Internal Revenue Code of 1986 is amended to read
24 as follows:

25 "(19) DISCLOSURES TO FACILITATE IDENTI-
26 FICATION OF INDIVIDUALS LIKELY TO BE INELI-

1 GIBLE FOR LOW-INCOME SUBSIDIES UNDER MEDI-
2 CARE PRESCRIPTION DRUG PROGRAM TO ASSIST SO-
3 CIAL SECURITY ADMINISTRATION'S OUTREACH TO
4 ELIGIBLE INDIVIDUALS.—
5 ''(A) IN GENERAL.—Upon written request
6 from the Commissioner of Social Security, the
7 following return information (including such in-
8 formation disclosed to the Social Security Ad-
9 ministration under paragraph (1) or (5)) shall
10 be disclosed to officers and employees of the So-
11 cial Security Administration, with respect to
12 any taxpayer identified by the Commissioner of
13 Social Security—
14 ''(i) return information for the appli-
15 cable year from returns with respect to
16 wages (as defined in section 3121(a) or
17 3401(a)) and payments of retirement in-
18 come (as described in paragraph (1) of this
19 subsection),
20 ''(ii) unearned income information
21 and income information of the taxpayer
22 from partnerships, trusts, estates, and sub-
23 chapter S corporations for the applicable
24 year,

1 "(iii) if the individual filed an income
2 tax return for the applicable year, the fil-
3 ing status, number of dependents, income
4 from farming, and income from self-em-
5 ployment, on such return,
6 "(iv) if the individual is a married in-
7 dividual filing a separate return for the ap-
8 plicable year, the social security number (if
9 reasonably available) of the spouse on such
10 return,
11 "(v) if the individual files a joint re-
12 turn for the applicable year, the social se-
13 curity number, unearned income informa-
14 tion, and income information from partner-
15 ships, trusts, estates, and subchapter S
16 corporations of the individual's spouse on
17 such return, and
18 "(vi) such other return information
19 relating to the individual (or the individ-
20 ual's spouse in the case of a joint return)
21 as is prescribed by the Secretary by regula-
22 tion as might indicate that the individual
23 is likely to be ineligible for a low-income
24 prescription drug subsidy under section
25 1860D–14 of the Social Security Act.

1 "(B) APPLICABLE YEAR.—For the pur-
2 poses of this paragraph, the term 'applicable
3 year' means the most recent taxable year for
4 which information is available in the Internal
5 Revenue Service's taxpayer information records.
6 "(C) RESTRICTION ON INDIVIDUALS FOR
7 WHOM DISCLOSURE MAY BE REQUESTED.—The
8 Commissioner of Social Security shall request
9 information under this paragraph only with re-
10 spect to—
11 "(i) individuals the Social Security
12 Administration has identified, using all
13 other reasonably available information, as
14 likely to be eligible for a low-income pre-
15 scription drug subsidy under section
16 1860D–14 of the Social Security Act and
17 who have not applied for such subsidy, and
18 "(ii) any individual the Social Security
19 Administration has identified as a spouse
20 of an individual described in clause (i).
21 "(D) RESTRICTION ON USE OF DISCLOSED
22 INFORMATION.—Return information disclosed
23 under this paragraph may be used only by offi-
24 cers and employees of the Social Security Ad-
25 ministration solely for purposes of identifying

1 individuals likely to be ineligible for a low-in-
2 come prescription drug subsidy under section
3 1860D–14 of the Social Security Act for use in
4 outreach efforts under section 1144 of the So-
5 cial Security Act.''.

6 (b) SAFEGUARDS.—Paragraph (4) of section 6103(p)
7 of such Code is amended—

8 (1) by striking ''(l)(19)'' each place it appears,
9 and

10 (2) by striking ''or (17)'' each place it appears
11 and inserting ''(17), or (19)''.

12 (c) CONFORMING AMENDMENT.—Paragraph (3) of
13 section 6103(a) of such Code is amended by striking
14 ''(19),''.

15 (d) EFFECTIVE DATE.—The amendments made by
16 this section shall apply to disclosures made after the date
17 which is 12 months after the date of the enactment of
18 this Act.

19 **SEC. 1802. COMPARATIVE EFFECTIVENESS RESEARCH**
20 **TRUST FUND; FINANCING FOR TRUST FUND.**

21 (a) ESTABLISHMENT OF TRUST FUND.—

22 (1) IN GENERAL.—Subchapter A of chapter 98
23 of the Internal Revenue Code of 1986 (relating to
24 trust fund code) is amended by adding at the end
25 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

1 the average number of individuals entitled to
2 benefits under part A, or enrolled under part B,
3 of title XVIII of the Social Security Act during
4 such fiscal year.

5 The amounts appropriated under paragraphs (1), (2), (3),
6 and (4)(B) shall be transferred from the Federal Hospital
7 Insurance Trust Fund and from the Federal Supple-
8 mentary Medical Insurance Trust Fund (established
9 under section 1841 of such Act), and from the Medicare
10 Prescription Drug Account within such Trust Fund, in
11 proportion (as estimated by the Secretary) to the total ex-
12 penditures during such fiscal year that are made under
13 title XVIII of such Act from the respective trust fund or
14 account.

15 "(c) FAIR SHARE PER CAPITA AMOUNT.—

16 "(1) COMPUTATION.—

17 "(A) IN GENERAL.—Subject to subpara-
18 graph (B), the fair share per capita amount
19 under this paragraph for a fiscal year (begin-
20 ning with fiscal year 2013) is an amount com-
21 puted by the Secretary of Health and Human
22 Services for such fiscal year that, when applied
23 under this section and subchapter B of chapter
24 34 of the Internal Revenue Code of 1986, will

1 result in revenues to the CERTF of
2 $375,000,000 for the fiscal year.
3 "(B) ALTERNATIVE COMPUTATION.—
4 "(i) IN GENERAL.—If the Secretary is
5 unable to compute the fair share per capita
6 amount under subparagraph (A) for a fis-
7 cal year, the fair share per capita amount
8 under this paragraph for the fiscal year
9 shall be the default amount determined
10 under clause (ii) for the fiscal year.
11 "(ii) DEFAULT AMOUNT.—The default
12 amount under this clause for—
13 "(I) fiscal year 2013 is equal to
14 $2; or
15 "(II) a subsequent year is equal
16 to the default amount under this
17 clause for the preceding fiscal year in-
18 creased by the annual percentage in-
19 crease in the medical care component
20 of the consumer price index (United
21 States city average) for the 12-month
22 period ending with April of the pre-
23 ceding fiscal year.
24 Any amount determined under subclause
25 (II) shall be rounded to the nearest penny.

1 "(2) LIMITATION ON MEDICARE FUNDING.—In
2 no case shall the amount transferred under sub-
3 section (b)(4)(B) for any fiscal year exceed
4 $90,000,000.
5 "(d) EXPENDITURES FROM FUND.—
6 "(1) IN GENERAL.—Subject to paragraph (2),
7 amounts in the CERTF are available, without the
8 need for further appropriations and without fiscal
9 year limitation, to the Secretary of Health and
10 Human Services for carrying out section 1181 of the
11 Social Security Act.
12 "(2) ALLOCATION FOR COMMISSION.—Not less
13 than the following amounts in the CERTF for a fis-
14 cal year shall be available to carry out the activities
15 of the Comparative Effectiveness Research Commis-
16 sion established under section 1181(b) of the Social
17 Security Act for such fiscal year:
18 "(A) For fiscal year 2010, $7,000,000.
19 "(B) For fiscal year 2011, $9,000,000.
20 "(C) For each fiscal year beginning with
21 2012, $10,000,000.
22 Nothing in this paragraph shall be construed as pre-
23 venting additional amounts in the CERTF from
24 being made available to the Comparative Effective-
25 ness Research Commission for such activities.

1 "(e) NET REVENUES.—For purposes of this section,
2 the term 'net revenues' means the amount estimated by
3 the Secretary based on the excess of—
4 "(1) the fees received in the Treasury under
5 subchapter B of chapter 34, over
6 "(2) the decrease in the tax imposed by chapter
7 1 resulting from the fees imposed by such sub-
8 chapter.".
9 (2) CLERICAL AMENDMENT.—The table of sec-
10 tions for such subchapter A is amended by adding
11 at the end thereof the following new item:

"Sec. 9511. Health Care Comparative Effectiveness Research Trust Fund.".

12 (b) FINANCING FOR FUND FROM FEES ON INSURED
13 AND SELF-INSURED HEALTH PLANS.—
14 (1) GENERAL RULE.—Chapter 34 of the Inter-
15 nal Revenue Code of 1986 is amended by adding at
16 the end the following new subchapter:

17 **"Subchapter B—Insured and Self-Insured**
18 **Health Plans**

"Sec. 4375. Health insurance.
"Sec. 4376. Self-insured health plans.
"Sec. 4377. Definitions and special rules.

19 **"SEC. 4375. HEALTH INSURANCE.**

20 "(a) IMPOSITION OF FEE.—There is hereby imposed
21 on each specified health insurance policy for each policy
22 year a fee equal to the fair share per capita amount deter-

1 mined under section 9511(c)(1) multiplied by the average
2 number of lives covered under the policy.

3 "(b) LIABILITY FOR FEE.—The fee imposed by sub-
4 section (a) shall be paid by the issuer of the policy.

5 "(c) SPECIFIED HEALTH INSURANCE POLICY.—For
6 purposes of this section:

7 "(1) IN GENERAL.—Except as otherwise pro-
8 vided in this section, the term 'specified health in-
9 surance policy' means any accident or health insur-
10 ance policy issued with respect to individuals resid-
11 ing in the United States.

12 "(2) EXEMPTION FOR CERTAIN POLICIES.—The
13 term 'specified health insurance policy' does not in-
14 clude any insurance if substantially all of its cov-
15 erage is of excepted benefits described in section
16 9832(c).

17 "(3) TREATMENT OF PREPAID HEALTH COV-
18 ERAGE ARRANGEMENTS.—

19 "(A) IN GENERAL.—In the case of any ar-
20 rangement described in subparagraph (B)—

21 "(i) such arrangement shall be treated
22 as a specified health insurance policy, and

23 "(ii) the person referred to in such
24 subparagraph shall be treated as the
25 issuer.

1 "(B) DESCRIPTION OF ARRANGEMENTS.—
2 An arrangement is described in this subpara-
3 graph if under such arrangement fixed pay-
4 ments or premiums are received as consider-
5 ation for any person's agreement to provide or
6 arrange for the provision of accident or health
7 coverage to residents of the United States, re-
8 gardless of how such coverage is provided or ar-
9 ranged to be provided.

10 **"SEC. 4376. SELF-INSURED HEALTH PLANS.**

11 "(a) IMPOSITION OF FEE.—In the case of any appli-
12 cable self-insured health plan for each plan year, there is
13 hereby imposed a fee equal to the fair share per capita
14 amount determined under section 9511(c)(1) multiplied by
15 the average number of lives covered under the plan.

16 "(b) LIABILITY FOR FEE.—
17 "(1) IN GENERAL.—The fee imposed by sub-
18 section (a) shall be paid by the plan sponsor.
19 "(2) PLAN SPONSOR.—For purposes of para-
20 graph (1) the term 'plan sponsor' means—
21 "(A) the employer in the case of a plan es-
22 tablished or maintained by a single employer,
23 "(B) the employee organization in the case
24 of a plan established or maintained by an em-
25 ployee organization,

1 "(C) in the case of—
2 "(i) a plan established or maintained
3 by 2 or more employers or jointly by 1 or
4 more employers and 1 or more employee
5 organizations,
6 "(ii) a multiple employer welfare ar-
7 rangement, or
8 "(iii) a voluntary employees' bene-
9 ficiary association described in section
10 501(c)(9),
11 the association, committee, joint board of trust-
12 ees, or other similar group of representatives of
13 the parties who establish or maintain the plan,
14 or
15 "(D) the cooperative or association de-
16 scribed in subsection (c)(2)(F) in the case of a
17 plan established or maintained by such a coop-
18 erative or association.
19 "(c) APPLICABLE SELF-INSURED HEALTH PLAN.—
20 For purposes of this section, the term 'applicable self-in-
21 sured health plan' means any plan for providing accident
22 or health coverage if—
23 "(1) any portion of such coverage is provided
24 other than through an insurance policy, and
25 "(2) such plan is established or maintained—

1 "(A) by one or more employers for the
2 benefit of their employees or former employees,
3 "(B) by one or more employee organiza-
4 tions for the benefit of their members or former
5 members,
6 "(C) jointly by 1 or more employers and 1
7 or more employee organizations for the benefit
8 of employees or former employees,
9 "(D) by a voluntary employees' beneficiary
10 association described in section 501(c)(9),
11 "(E) by any organization described in sec-
12 tion 501(c)(6), or
13 "(F) in the case of a plan not described in
14 the preceding subparagraphs, by a multiple em-
15 ployer welfare arrangement (as defined in sec-
16 tion 3(40) of Employee Retirement Income Se-
17 curity Act of 1974), a rural electric cooperative
18 (as defined in section 3(40)(B)(iv) of such Act),
19 or a rural telephone cooperative association (as
20 defined in section 3(40)(B)(v) of such Act).

21 **"SEC. 4377. DEFINITIONS AND SPECIAL RULES.**

22 "(a) DEFINITIONS.—For purposes of this sub-
23 chapter—
24 "(1) ACCIDENT AND HEALTH COVERAGE.—The
25 term 'accident and health coverage' means any cov-

1 erage which, if provided by an insurance policy,
2 would cause such policy to be a specified health in-
3 surance policy (as defined in section 4375(c)).
4 ''(2) INSURANCE POLICY.—The term 'insurance
5 policy' means any policy or other instrument where-
6 by a contract of insurance is issued, renewed, or ex-
7 tended.
8 ''(3) UNITED STATES.—The term 'United
9 States' includes any possession of the United States.
10 ''(b) TREATMENT OF GOVERNMENTAL ENTITIES.—
11 ''(1) IN GENERAL.—For purposes of this sub-
12 chapter—
13 ''(A) the term 'person' includes any gov-
14 ernmental entity, and
15 ''(B) notwithstanding any other law or rule
16 of law, governmental entities shall not be ex-
17 empt from the fees imposed by this subchapter
18 except as provided in paragraph (2).
19 ''(2) TREATMENT OF EXEMPT GOVERNMENTAL
20 PROGRAMS.—In the case of an exempt governmental
21 program, no fee shall be imposed under section 4375
22 or section 4376 on any covered life under such pro-
23 gram.

1 "(3) EXEMPT GOVERNMENTAL PROGRAM DE-
2 FINED.—For purposes of this subchapter, the term
3 'exempt governmental program' means—
4 "(A) any insurance program established
5 under title XVIII of the Social Security Act,
6 "(B) the medical assistance program es-
7 tablished by title XIX or XXI of the Social Se-
8 curity Act,
9 "(C) any program established by Federal
10 law for providing medical care (other than
11 through insurance policies) to individuals (or
12 the spouses and dependents thereof) by reason
13 of such individuals being—
14 "(i) members of the Armed Forces of
15 the United States, or
16 "(ii) veterans, and
17 "(D) any program established by Federal
18 law for providing medical care (other than
19 through insurance policies) to members of In-
20 dian tribes (as defined in section 4(d) of the In-
21 dian Health Care Improvement Act).
22 "(c) TREATMENT AS TAX.—For purposes of subtitle
23 F, the fees imposed by this subchapter shall be treated
24 as if they were taxes.

1 "(d) NO COVER OVER TO POSSESSIONS.—Notwith-
2 standing any other provision of law, no amount collected
3 under this subchapter shall be covered over to any posses-
4 sion of the United States.".
5 (2) CLERICAL AMENDMENTS.—
6 (A) Chapter 34 of such Code is amended
7 by striking the chapter heading and inserting
8 the following:

9 **"CHAPTER 34—TAXES ON CERTAIN**
10 **INSURANCE POLICIES**

"SUBCHAPTER A. POLICIES ISSUED BY FOREIGN INSURERS
"SUBCHAPTER B. INSURED AND SELF-INSURED HEALTH PLANS

11 **"Subchapter A—Policies Issued By Foreign**
12 **Insurers".**

13 (B) The table of chapters for subtitle D of
14 such Code is amended by striking the item re-
15 lating to chapter 34 and inserting the following
16 new item:

"CHAPTER 34—TAXES ON CERTAIN INSURANCE POLICIES".

17 (3) EFFECTIVE DATE.—The amendments made
18 by this subsection shall apply with respect to policies
19 and plans for portions of policy or plan years begin-
20 ning 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,''.

1 (2) AVAILABILITY.—Subsection (f)(2) of such
2 section is amended by striking ''2010'' and inserting
3 ''2014 or until expended''.
4 (c) REPORTS.—
5 (1) QUALITY IMPROVEMENT AND SAVINGS.—
6 Subsection (e)(3) of such section is amended by
7 striking ''December 1, 2008'' and inserting ''March
8 31, 2011''.
9 (2) FINAL REPORT.—Subsection (e)(4) of such
10 section is amended by striking ''May 1, 2010'' and
11 inserting ''March 31, 2013''.

12 **SEC. 1904. GRANTS TO STATES FOR QUALITY HOME VISITA-**
13 **TION PROGRAMS FOR FAMILIES WITH YOUNG**
14 **CHILDREN AND FAMILIES EXPECTING CHIL-**
15 **DREN.**

16 Part B of title IV of the Social Security Act (42
17 U.S.C. 621–629i) is amended by adding at the end the
18 following:

19 **''Subpart 3—Support for Quality Home Visitation**
20 **Programs**

21 **''SEC. 440. HOME VISITATION PROGRAMS FOR FAMILIES**
22 **WITH YOUNG CHILDREN AND FAMILIES EX-**
23 **PECTING CHILDREN.**

24 ''(a) PURPOSE.—The purpose of this section is to im-
25 prove the well-being, health, and development of children

1 by enabling the establishment and expansion of high qual-
2 ity programs providing voluntary home visitation for fami-
3 lies with young children and families expecting children.
4 "(b) GRANT APPLICATION.—A State that desires to
5 receive a grant under this section shall submit to the Sec-
6 retary for approval, at such time and in such manner as
7 the Secretary may require, an application for the grant
8 that includes the following:
9 "(1) DESCRIPTION OF HOME VISITATION PRO-
10 GRAMS.—A description of the high quality programs
11 of home visitation for families with young children
12 and families expecting children that will be sup-
13 ported by a grant made to the State under this sec-
14 tion, the outcomes the programs are intended to
15 achieve, and the evidence supporting the effective-
16 ness of the programs.
17 "(2) RESULTS OF NEEDS ASSESSMENT.—The
18 results of a statewide needs assessment that de-
19 scribes—
20 "(A) the number, quality, and capacity of
21 home visitation programs for families with
22 young children and families expecting children
23 in the State;
24 "(B) the number and types of families who
25 are receiving services under the programs;

1 "(C) the sources and amount of funding
2 provided to the programs;
3 "(D) the gaps in home visitation in the
4 State, including identification of communities
5 that are in high need of the services; and
6 "(E) training and technical assistance ac-
7 tivities designed to achieve or support the goals
8 of the programs.
9 "(3) ASSURANCES.—Assurances from the State
10 that—
11 "(A) in supporting home visitation pro-
12 grams using funds provided under this section,
13 the State shall identify and prioritize serving
14 communities that are in high need of such serv-
15 ices, especially communities with a high propor-
16 tion of low-income families or a high incidence
17 of child maltreatment;
18 "(B) the State will reserve 5 percent of the
19 grant funds for training and technical assist-
20 ance to the home visitation programs using
21 such funds;
22 "(C) in supporting home visitation pro-
23 grams using funds provided under this section,
24 the State will promote coordination and collabo-
25 ration with other home visitation programs (in-

1 cluding programs funded under title XIX) and
2 with other child and family services, health
3 services, income supports, and other related as-
4 sistance;
5 ''(D) home visitation programs supported
6 using such funds will, when appropriate, pro-
7 vide referrals to other programs serving chil-
8 dren and families; and
9 ''(E) the State will comply with subsection
10 (i), and cooperate with any evaluation con-
11 ducted under subsection (j).
12 ''(4) OTHER INFORMATION.—Such other infor-
13 mation as the Secretary may require.
14 ''(c) ALLOTMENTS.—
15 ''(1) INDIAN TRIBES.—From the amount re-
16 served under subsection (l)(2) for a fiscal year, the
17 Secretary shall allot to each Indian tribe that meets
18 the requirement of subsection (d), if applicable, for
19 the fiscal year the amount that bears the same ratio
20 to the amount so reserved as the number of children
21 in the Indian tribe whose families have income that
22 does not exceed 200 percent of the poverty line bears
23 to the total number of children in such Indian tribes
24 whose families have income that does not exceed 200
25 percent of the poverty line.

1 "(2) STATES AND TERRITORIES.—From the
2 amount appropriated under subsection (m) for a fis-
3 cal year that remains after making the reservations
4 required by subsection (l), the Secretary shall allot
5 to each State that is not an Indian tribe and that
6 meets the requirement of subsection (d), if applica-
7 ble, for the fiscal year the amount that bears the
8 same ratio to the remainder of the amount so appro-
9 priated as the number of children in the State whose
10 families have income that does not exceed 200 per-
11 cent of the poverty line bears to the total number of
12 children in such States whose families have income
13 that does not exceed 200 percent of the poverty line.
14 "(3) REALLOTMENTS.—The amount of any al-
15 lotment to a State under a paragraph of this sub-
16 section for any fiscal year that the State certifies to
17 the Secretary will not be expended by the State pur-
18 suant to this section shall be available for reallot-
19 ment using the allotment methodology specified in
20 that paragraph. Any amount so reallotted to a State
21 is deemed part of the allotment of the State under
22 this subsection.
23 "(d) MAINTENANCE OF EFFORT.—Beginning with
24 fiscal year 2011, a State meets the requirement of this
25 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 subsection (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.

1 ‘‘(f) ELIGIBLE EXPENDITURES.—
2 ‘‘(1) IN GENERAL.—In this section, the term
3 ‘eligible expenditures’—
4 ‘‘(A) means expenditures to provide vol-
5 untary home visitation for as many families
6 with young children (under the age of school
7 entry) and families expecting children as prac-
8 ticable, through the implementation or expan-
9 sion of high quality home visitation programs
10 that—
11 ‘‘(i) adhere to clear evidence-based
12 models of home visitation that have dem-
13 onstrated positive effects on important pro-
14 gram-determined child and parenting out-
15 comes, such as reducing abuse and neglect
16 and improving child health and develop-
17 ment;
18 ‘‘(ii) employ well-trained and com-
19 petent staff, maintain high quality super-
20 vision, provide for ongoing training and
21 professional development, and show strong
22 organizational capacity to implement such
23 a program;

1 "(iii) establish appropriate linkages
2 and referrals to other community resources
3 and supports;
4 "(iv) monitor fidelity of program im-
5 plementation to ensure that services are
6 delivered according to the specified model;
7 and
8 "(v) provide parents with—
9 "(I) knowledge of age-appro-
10 priate child development in cognitive,
11 language, social, emotional, and motor
12 domains (including knowledge of sec-
13 ond language acquisition, in the case
14 of English language learners);
15 "(II) knowledge of realistic ex-
16 pectations of age-appropriate child be-
17 haviors;
18 "(III) knowledge of health and
19 wellness issues for children and par-
20 ents;
21 "(IV) modeling, consulting, and
22 coaching on parenting practices;
23 "(V) skills to interact with their
24 child to enhance age-appropriate de-
25 velopment;

1 "(VI) skills to recognize and seek
2 help for issues related to health, devel-
3 opmental delays, and social, emo-
4 tional, and behavioral skills; and
5 "(VII) activities designed to help
6 parents become full partners in the
7 education of their children;
8 "(B) includes expenditures for training,
9 technical assistance, and evaluations related to
10 the programs; and
11 "(C) does not include any expenditure with
12 respect to which a State has submitted a claim
13 for payment under any other provision of Fed-
14 eral law.
15 "(2) PRIORITY FUNDING FOR PROGRAMS WITH
16 STRONGEST EVIDENCE.—
17 "(A) IN GENERAL.—The expenditures, de-
18 scribed in paragraph (1), of a State for a fiscal
19 year that are attributable to the cost of pro-
20 grams that do not adhere to a model of home
21 visitation with the strongest evidence of effec-
22 tiveness shall not be considered eligible expendi-
23 tures for the fiscal year to the extent that the
24 total of the expenditures exceeds the applicable
25 percentage for the fiscal year of the allotment

1 of the State under subsection (c) for the fiscal
2 year.
3 "(B) APPLICABLE PERCENTAGE DE-
4 FINED.—In subparagraph (A), the term 'appli-
5 cable percentage' means, with respect to a fiscal
6 year—
7 "(i) 60 percent for fiscal year 2010;
8 "(ii) 55 percent for fiscal year 2011;
9 "(iii) 50 percent for fiscal year 2012;
10 "(iv) 45 percent for fiscal year 2013;
11 or
12 "(v) 40 percent for fiscal year 2014.
13 "(g) NO USE OF OTHER FEDERAL FUNDS FOR
14 STATE MATCH.—A State to which a grant is made under
15 this section may not expend any Federal funds to meet
16 the State share of the cost of an eligible expenditure for
17 which the State receives a payment under this section.
18 "(h) WAIVER AUTHORITY.—
19 "(1) IN GENERAL.—The Secretary may waive
20 or modify the application of any provision of this
21 section, other than subsection (b) or (f), to an In-
22 dian tribe if the failure to do so would impose an
23 undue burden on the Indian tribe.

1 "(2) SPECIAL RULE.—An Indian tribe is
2 deemed to meet the requirement of subsection (d)
3 for purposes of subsections (c) and (e) if—
4 "(A) the Secretary waives the requirement;
5 or
6 "(B) the Secretary modifies the require-
7 ment, and the Indian tribe meets the modified
8 requirement.
9 "(i) STATE REPORTS.—Each State to which a grant
10 is made under this section shall submit to the Secretary
11 an annual report on the progress made by the State in
12 addressing the purposes of this section. Each such report
13 shall include a description of—
14 "(1) the services delivered by the programs that
15 received funds from the grant;
16 "(2) the characteristics of each such program,
17 including information on the service model used by
18 the program and the performance of the program;
19 "(3) the characteristics of the providers of serv-
20 ices through the program, including staff qualifica-
21 tions, work experience, and demographic characteris-
22 tics;
23 "(4) the characteristics of the recipients of serv-
24 ices provided through the program, including the

1 number of the recipients, the demographic charac-
2 teristics of the recipients, and family retention;
3 "(5) the annual cost of implementing the pro-
4 gram, including the cost per family served under the
5 program;
6 "(6) the outcomes experienced by recipients of
7 services through the program;
8 "(7) the training and technical assistance pro-
9 vided to aid implementation of the program, and
10 how the training and technical assistance contrib-
11 uted to the outcomes achieved through the program;
12 "(8) the indicators and methods used to mon-
13 itor whether the program is being implemented as
14 designed; and
15 "(9) other information as determined necessary
16 by the Secretary.
17 "(j) EVALUATION.—
18 "(1) IN GENERAL.—The Secretary shall, by
19 grant or contract, provide for the conduct of an
20 independent evaluation of the effectiveness of home
21 visitation programs receiving funds provided under
22 this section, which shall examine the following:
23 "(A) The effect of home visitation pro-
24 grams on child and parent outcomes, including
25 child maltreatment, child health and develop-

1 ment, school readiness, and links to community
2 services.
3 "(B) The effectiveness of home visitation
4 programs on different populations, including
5 the extent to which the ability of programs to
6 improve outcomes varies across programs and
7 populations.
8 "(2) REPORTS TO THE CONGRESS.—
9 "(A) INTERIM REPORT.—Within 3 years
10 after the date of the enactment of this section,
11 the Secretary shall submit to the Congress an
12 interim report on the evaluation conducted pur-
13 suant to paragraph (1).
14 "(B) FINAL REPORT.—Within 5 years
15 after the date of the enactment of this section,
16 the Secretary shall submit to the Congress a
17 final report on the evaluation conducted pursu-
18 ant to paragraph (1).
19 "(k) ANNUAL REPORTS TO THE CONGRESS.—The
20 Secretary shall submit annually to the Congress a report
21 on the activities carried out using funds made available
22 under this section, which shall include a description of the
23 following:
24 "(1) The high need communities targeted by
25 States for programs carried out under this section.

1 "(2) The service delivery models used in the
2 programs receiving funds provided under this sec-
3 tion.
4 "(3) The characteristics of the programs, in-
5 cluding—
6 "(A) the qualifications and demographic
7 characteristics of program staff; and
8 "(B) recipient characteristics including the
9 number of families served, the demographic
10 characteristics of the families served, and fam-
11 ily retention and duration of services.
12 "(4) The outcomes reported by the programs.
13 "(5) The research-based instruction, materials,
14 and activities being used in the activities funded
15 under the grant.
16 "(6) The training and technical activities, in-
17 cluding on-going professional development, provided
18 to the programs.
19 "(7) The annual costs of implementing the pro-
20 grams, including the cost per family served under
21 the programs.
22 "(8) The indicators and methods used by States
23 to monitor whether the programs are being been im-
24 plemented as designed.

1 "(l) RESERVATIONS OF FUNDS.—From the amounts
2 appropriated for a fiscal year under subsection (m), the
3 Secretary shall reserve—
4 "(1) an amount equal to 5 percent of the
5 amounts to pay the cost of the evaluation provided
6 for in subsection (j), and the provision to States of
7 training and technical assistance, including the dis-
8 semination of best practices in early childhood home
9 visitation; and
10 "(2) after making the reservation required by
11 paragraph (1), an amount equal to 3 percent of the
12 amount so appropriated, to pay for grants to Indian
13 tribes under this section.
14 "(m) APPROPRIATIONS.—Out of any money in the
15 Treasury of the United States not otherwise appropriated,
16 there is appropriated to the Secretary to carry out this
17 section—
18 "(1) $50,000,000 for fiscal year 2010;
19 "(2) $100,000,000 for fiscal year 2011;
20 "(3) $150,000,000 for fiscal year 2012;
21 "(4) $200,000,000 for fiscal year 2013; and
22 "(5) $250,000,000 for fiscal year 2014.
23 "(n) INDIAN TRIBES TREATED AS STATES.—In this
24 section, paragraphs (4), (5), and (6) of section 431(a)
25 shall apply.".

1 **SEC. 1905. IMPROVED COORDINATION AND PROTECTION**
2 **FOR DUAL ELIGIBLES.**

3 Title XI of the Social Security Act is amended by
4 inserting after section 1150 the following new section:

5 "IMPROVED COORDINATION AND PROTECTION FOR DUAL
6 ELIGIBLES

7 "SEC. 1150A. (a) IN GENERAL.—The Secretary shall
8 provide, through an identifiable office or program within
9 the Centers for Medicare & Medicaid Services, for a fo-
10 cused effort to provide for improved coordination between
11 Medicare and Medicaid and protection in the case of dual
12 eligibles (as defined in subsection (e)). The office or pro-
13 gram shall—

14 "(1) review Medicare and Medicaid policies re-
15 lated to enrollment, benefits, service delivery, pay-
16 ment, and grievance and appeals processes under
17 parts A and B of title XVIII, under the Medicare
18 Advantage program under part C of such title, and
19 under title XIX;

20 "(2) identify areas of such policies where better
21 coordination and protection could improve care and
22 costs; and

23 "(3) issue guidance to States regarding improv-
24 ing such coordination and protection.

25 "(b) ELEMENTS.—The improved coordination and
26 protection under this section shall include efforts—

1 "(1) to simplify access of dual eligibles to bene-
2 fits and services under Medicare and Medicaid;
3 "(2) to improve care continuity for dual eligi-
4 bles and ensure safe and effective care transitions;
5 "(3) to harmonize regulatory conflicts between
6 Medicare and Medicaid rules with regard to dual eli-
7 gibles; and
8 "(4) to improve total cost and quality perform-
9 ance under Medicare and Medicaid for dual eligibles.
10 "(c) RESPONSIBILITIES.—In carrying out this sec-
11 tion, the Secretary shall provide for the following:
12 "(1) An examination of Medicare and Medicaid
13 payment systems to develop strategies to foster more
14 integrated and higher quality care.
15 "(2) Development of methods to facilitate ac-
16 cess to post-acute and community-based services and
17 to identify actions that could lead to better coordina-
18 tion of community-based care.
19 "(3) A study of enrollment of dual eligibles in
20 the Medicare Savings Program (as defined in section
21 1144(c)(7)), under Medicaid, and in the low-income
22 subsidy program under section 1860D–14 to identify
23 methods to more efficiently and effectively reach and
24 enroll dual eligibles.

1 "(4) An assessment of communication strate-
2 gies for dual eligibles to determine whether addi-
3 tional informational materials or outreach is needed,
4 including an assessment of the Medicare website, 1–
5 800–MEDICARE, and the Medicare handbook.
6 "(5) Research and evaluation of areas where
7 service utilization, quality, and access to cost sharing
8 protection could be improved and an assessment of
9 factors related to enrollee satisfaction with services
10 and care delivery.
11 "(6) Collection (and making available to the
12 public) of data and a database that describe the eli-
13 gibility, benefit and cost-sharing assistance available
14 to dual eligibles by State.
15 "(7) Monitoring total combined Medicare and
16 Medicaid program costs in serving dual eligibles and
17 making recommendations for optimizing total quality
18 and cost performance across both programs.
19 "(8) Coordination of activities relating to Medi-
20 care Advantage plans under 1859(b)(6)(B)(ii) and
21 Medicaid.
22 "(d) PERIODIC REPORTS.—Not later than 1 year
23 after the date of the enactment of this section and every
24 3 years thereafter the Secretary shall submit to Congress

1 a report on progress in activities conducted under this sec-
2 tion.

3 ''(e) DEFINITIONS.—In this section:

4 ''(1) DUAL ELIGIBLE.—The term 'dual eligible'
5 means an individual who is dually eligible for bene-
6 fits under title XVIII, and medical assistance under
7 title XIX, including such individuals who are eligible
8 for benefits under the Medicare Savings Program
9 (as defined in section 1144(c)(7)).

10 ''(2) MEDICARE; MEDICAID.—The terms 'Medi-
11 care' and 'Medicaid' mean the programs under titles
12 XVIII and XIX, respectively.''.

13 **SEC. 1906. ASSESSMENT OF MEDICARE COST-INTENSIVE**
14 **DISEASES AND CONDITIONS.**

15 (a) INITIAL ASSESSMENT.—

16 (1) IN GENERAL.—The Administrator of the
17 Centers for Medicare & Medicaid Services shall con-
18 duct an assessment of the diseases and conditions
19 that are the most cost-intensive for the Medicare
20 program. The assessment shall inform research pri-
21 orities within the Department of Health and Human
22 Services in order improve the prevention, or treat-
23 ment or cure, of such diseases and conditions.

24 (2) REPORT.— Not later than January 1,
25 2011, the Administrator shall submit to the Sec-

1 retary of Health and Human Services a report on
2 such assessment and the Secretary shall transmit
3 such report to the Congress.
4 (b) UPDATES OF ASSESSMENT.—Not later than Jan-
5 uary 1, 2013, and biennially thereafter, the Administrator
6 of the Centers for Medicare & Medicaid Services shall re-
7 view and update the assessment described in subsection
8 (a) and make such recommendations to the Secretary on
9 changes in research priorities referred to in such sub-
10 section as may be appropriate. The Secretary shall submit
11 to the Congress a report on such recommendations.
12 (c) MEDICARE COST-INTENSIVE RESEARCH FUND.—
13 There is established in the Treasury of the United States
14 a Fund to be known as the Medicare Cost-Intensive Re-
15 search Fund (in this subsection referred to as the
16 ''Fund''), consisting of such amounts as may be appro-
17 priated or credited to such Fund for research priorities
18 identified as a result of the assessments conducted under
19 this section.

20 **DIVISION C—PUBLIC HEALTH**
21 **AND WORKFORCE DEVELOP-**
22 **MENT** [*TEXT OMITTED BECAUSE*
23 *OUTSIDE JURISDICTION OF COM-*
24 *MITTEE ON WAYS AND MEANS*]