H.L.C.

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(Original Signature of Member)

111TH CONGRESS
1ST SESSION

H. R. _____

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

IN THE HOUSE OF REPRESENTATIVES

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

A BILL

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

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

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

(a) SHORT TITLE.—This Act may be cited as the ''Affordable Health Care for America Act''.

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

DIVISION A—AFFORDABLE HEALTH CARE CHOICES

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

(a) PURPOSE.—

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

Americans and reduce the growth in health care spending.

(2) BUILDING ON CURRENT SYSTEM.—This division achieves this purpose by building on what works in today's health care system, while repairing the aspects that are broken.

(3) INSURANCE REFORMS.—This division—

(A) enacts strong insurance market reforms;

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

(C) includes sliding scale affordability credits; and

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

so that all Americans have coverage of essential health benefits.

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

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

TITLE I—IMMEDIATE REFORMS

TITLE II—PROTECTIONS AND STANDARDS FOR QUALIFIED HEALTH BENEFITS PLANS

Subtitle A—General Standards

Subtitle B—Standards Guaranteeing Access to Affordable Coverage

Subtitle C—Standards Guaranteeing Access to Essential Benefits

Subtitle D—Additional Consumer Protections

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

(1) ACCEPTABLE COVERAGE.—The term ''acceptable coverage'' has the meaning given such term in section 302(d)(2).

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

(3) COMMISSIONER.—The term ''Commissioner'' means the Health Choices Commissioner established under section 241.

(4) COST-SHARING.—The term ''cost-sharing'' includes deductibles, coinsurance, copayments, and similar charges, but does not include premiums, balance billing amounts for non-network providers, or spending for non-covered services.

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

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

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

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

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

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

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

(7) ENHANCED PLAN.—The term ''enhanced plan'' has the meaning given such term in section 303(c).

(8) ESSENTIAL BENEFITS PACKAGE.—The term ''essential benefits package'' is defined in section 222(a).

(9) EXCHANGE-PARTICIPATING HEALTH BENEFITS PLAN.—The term ''Exchange-participating health benefits plan'' means a qualified health benefits plan that is offered through the Health Insurance Exchange and may be purchased directly from

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

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

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

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

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

(A) described in paragraph (1) of subsection (c) of such section; or

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

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

(15) HEALTH INSURANCE EXCHANGE.—The term ''Health Insurance Exchange'' means the Health Insurance Exchange established under section 301.

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

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

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

(19) MEDICAID ELIGIBLE INDIVIDUAL.—The term ''Medicaid eligible individual'' means an indi-

vidual who is eligible for medical assistance under Medicaid.

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

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

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

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

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

(23) PREMIUM PLAN; PREMIUM-PLUS PLAN.—The terms ''premium plan'' and ''premium-plus plan'' have the meanings given such terms in section 303(c).

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

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

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

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

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

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

(25) QUALIFIED HEALTH BENEFITS PLAN.—The term ''qualified health benefits plan'' means a health benefits plan that—

(A) meets the requirements for such a plan under title II and includes the public health insurance option; and

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

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

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

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

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

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

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

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

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

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

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

TITLE I—IMMEDIATE REFORMS

SEC. 101. NATIONAL HIGH-RISK POOL PROGRAM.

(a) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall establish a temporary national high-risk

pool program (in this section referred to as the ''program'') to provide health benefits to eligible individuals during the period beginning on January 1, 2010, and, subject to subsection (h)(3)(B), ending on the date on which the Health Insurance Exchange is established.

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

(c) ELIGIBILITY.—For purposes of this section, the term ''eligible individual'' means an individual—

(1) who—

(A) is not eligible for—

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

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

(B) who—

(i) is an eligible individual under section 2741(b) of the Public Health Service Act; or

(ii) is medically eligible for the program by virtue of being an individual described in subsection (d) at any time during the 6-month period ending on the date the individual applies for high-risk pool coverage under this section;

(2) who is the spouse or dependent of an individual who is described in paragraph (1); or

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

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

(d) MEDICALLY ELIGIBLE REQUIREMENTS.—For purposes of subsection (c)(1)(B)(ii), an individual described in this subsection is an individual—

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

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

(B) was offered such coverage—

(i) under terms that limit the coverage for such a preexisting condition; or

(ii) at a premium rate that is above the premium rate for high risk pool coverage under this section; or

(2) who has an eligible medical condition as defined by the Secretary.

In making a determination under paragraph (1) of whether an individual was offered individual coverage at a premium rate above the premium rate for high risk pool coverage, the Secretary shall make adjustments to offset differences in premium rating that are attributable solely to differences in age rating.

(e) ENROLLMENT.—To enroll in coverage in the program, an individual shall—

(1) submit to the Secretary an application for participation in the program, at such time, in such manner, and containing such information as the Secretary shall require;

(2) attest that the individual is an eligible individual and is a resident of one of the 50 States or the District of Columbia; and

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

(f) PROTECTION AGAINST DUMPING RISKS BY INSURERS.—

(1) IN GENERAL.—The Secretary shall establish criteria for determining whether health insurance issuers and employment-based health plans have discouraged an individual from remaining enrolled in prior coverage based on that individual's health status.

(2) SANCTIONS.—An issuer or employment-based health plan shall be responsible for reimbursing the program for the medical expenses incurred by the program for an individual who, based on criteria established by the Secretary, the Secretary finds was encouraged by the issuer to disenroll from health benefits coverage prior to enrolling in the program. The criteria shall include at least the following circumstances:

(A) In the case of prior coverage obtained through an employer, the provision by the employer, group health plan, or the issuer of

money or other financial consideration for disenrolling from the coverage.

(B) In the case of prior coverage obtained directly from an issuer or under an employment-based health plan—

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

(ii) in the case of an individual whose premium for the prior coverage exceeded the premium required by the program (adjusted based on the age factors applied to the prior coverage)—

(I) the prior coverage is a policy that is no longer being actively marketed (as defined by the Secretary) by the issuer; or

(II) the prior coverage is a policy for which duration of coverage form issue or health status are factors that can be considered in determining premiums at renewal.

(3) CONSTRUCTION.—Nothing in this subsection shall be construed as constituting exclusive remedies for violations of criteria established under

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

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

(1) PREMIUM.—The monthly premium charged to eligible individuals for coverage under the program—

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

(B) shall be set at a level that does not exceed 125 percent of the prevailing standard rate for comparable coverage in the individual market; and

(C) shall be adjusted for geographic variation in costs.

Health insurance issuers shall provide such information as the Secretary may require to determine prevailing standard rates under this paragraph. The Secretary shall establish standard rates in consultation with the National Association of Insurance Commissioners.

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

retary and shall be consistent with the basic categories in the essential benefits package described in section 222. Under such benefits package—

(A) the annual deductible for such benefits may not be higher than $1,500 for an individual or such higher amount for a family as determined by the Secretary;

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

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

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

(4) APPEALS.—The Secretary shall establish an appeals process for individuals to appeal a determination of the Secretary—

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

(B) with respect to eligibility determinations made by the Secretary under this section.

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

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

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

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

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

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

(B) provide for other program integrity methods.

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

(h) FUNDING; TERMINATION OF AUTHORITY.—

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

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

penses, the Secretary shall make such adjustments as are necessary to eliminate such deficit, including reducing benefits, increasing premiums, or establishing waiting lists.

(3) TERMINATION OF AUTHORITY.—

(A) IN GENERAL.—Except as provided in subparagraph (B), coverage of eligible individuals under a high-risk pool shall terminate as of the date on which the Health Insurance Exchange is established.

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

SEC. 102. ENSURING VALUE AND LOWER PREMIUMS.

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

"SEC. 2714. ENSURING VALUE AND LOWER PREMIUMS.

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

"(b) IMPLEMENTATION.—The Secretary shall establish a uniform definition of medical loss ratio and methodology for determining how to calculate it based on the average medical loss ratio in a health insurance issuer's book of business for the small and large group market. Such methodology shall be designed to take into account the special circumstances of smaller plans, different types of plans, and newer plans. In determining the medical loss ratio, the Secretary shall exclude State taxes and licensing or regulatory fees. Such methodology shall be designed and exceptions shall be established to ensure adequate participation by health insurance issuers, competition in the health insurance market, and value for consumers so that their premiums are used for services.

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

date that health insurance coverage is offered through the Health Insurance Exchange.''.

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

''SEC. 2754. ENSURING VALUE AND LOWER PREMIUMS.

''The provisions of section 2714 shall apply to health insurance coverage offered in the individual market in the same manner as such provisions apply to health insurance coverage offered in the small or large group market except to the extent the Secretary determines that the application of such section may destabilize the existing individual market.''.

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

SEC. 103. ENDING HEALTH INSURANCE RESCISSION ABUSE.

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

(1) in its heading, by inserting ''**AND CONTINUATION IN FORCE, INCLUDING PROHIBI-**

TION OF RESCISSION,'' after ''**GUARANTEED RENEWABILITY**''; and

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

(b) SECRETARIAL GUIDANCE REGARDING RESCISSIONS.—

(1) GROUP HEALTH INSURANCE MARKET.—Section 2712 of such Act (42 U.S.C. 300gg–12) is amended by adding at the end the following:

''(f) RESCISSION.—A health insurance issuer may rescind group health insurance coverage only upon clear and convincing evidence of fraud described in subsection (b)(2), under procedures that provide for independent, external third-party review.''.

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

''(f) RESCISSION.—A health insurance issuer may rescind individual health insurance coverage only upon clear and convincing evidence of fraud described in subsection (b)(2), under procedures that provide for independent, external third-party review.''.

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

ance implementing the amendments made by paragraphs (1) and (2), including procedures for independent, external third-party review.

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

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

"SEC. 2746. OPPORTUNITY FOR INDEPENDENT, EXTERNAL THIRD-PARTY REVIEW IN CASES OF RESCISSION.

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

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

(2) APPLICATION TO GROUP HEALTH INSURANCE.—Such title is further amended by adding after section 2702 the following new section:

"SEC. 2703. OPPORTUNITY FOR INDEPENDENT, EXTERNAL THIRD-PARTY REVIEW IN CASES OF RESCISSION.

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

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

SEC. 104. SUNSHINE ON PRICE GOUGING BY HEALTH INSURANCE ISSUERS.

The Secretary of Health and Human Services, in conjunction with States, shall establish a process for the annual review of increases in premiums for health insurance coverage. Such process shall require health insurance issuers to submit a justification for any premium increases prior to implementation of the increase.

SEC. 105. REQUIRING THE OPTION OF EXTENSION OF DEPENDENT COVERAGE FOR UNINSURED YOUNG ADULTS.

(a) UNDER GROUP HEALTH PLANS.—

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

"SEC. 2703. REQUIRING THE OPTION OF EXTENSION OF DEPENDENT COVERAGE FOR UNINSURED YOUNG ADULTS.

''(a) IN GENERAL.—A group health plan and a health insurance issuer offering health insurance coverage in connection with a group health plan that provides coverage for dependent children shall make available such coverage, at the option of the participant involved, for one or more qualified children (as defined in subsection (b)) of the participant.

''(b) QUALIFIED CHILD DEFINED.—In this section, the term 'qualified child' means, with respect to a participant in a group health plan or group health insurance coverage, an individual who (but for age) would be treated as a dependent child of the participant under such plan or coverage and who—

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

''(2) is not enrolled as a participant, beneficiary, or enrollee (other than under this section,

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

''(c) PREMIUMS.—Nothing in this section shall be construed as preventing a group health plan or health insurance issuer with respect to group health insurance coverage from increasing the premiums otherwise required for coverage provided under this section consistent with standards established by the Secretary based upon family size.''.

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

(A) IN GENERAL.—Part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 is amended by inserting after section 703 the following new section:

''SEC. 704. REQUIRING THE OPTION OF EXTENSION OF DEPENDENT COVERAGE FOR UNINSURED YOUNG ADULTS.

''(a) IN GENERAL.—A group health plan and a health insurance issuer offering health insurance coverage in connection with a group health plan that provides coverage for dependent children shall make available such coverage, at the option of the participant involved, for one or more

qualified children (as defined in subsection (b)) of the participant.

''(b) QUALIFIED CHILD DEFINED.—In this section, the term 'qualified child' means, with respect to a participant in a group health plan or group health insurance coverage, an individual who (but for age) would be treated as a dependent child of the participant under such plan or coverage and who—

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

''(2) is not enrolled as a participant, beneficiary, or enrollee (other than under this section) under any health insurance coverage or group health plan.

''(c) PREMIUMS.—Nothing in this section shall be construed as preventing a group health plan or health insurance issuer with respect to group health insurance coverage from increasing the premiums otherwise required for coverage provided under this section consistent with standards established by the Secretary based upon family size.''.

(B) CLERICAL AMENDMENT.—The table of contents of such Act is amended by inserting after the item relating to section 703 the following new item:

''Sec. 704. Requiring the option of extension of dependent coverage for uninsured young adults.''.

(3) IRC.—

(A) IN GENERAL.—Subchapter A of chapter 100 of the Internal Revenue Code of 1986 is amended by adding at the end the following new section:

"SEC. 9804. REQUIRING THE OPTION OF EXTENSION OF DEPENDENT COVERAGE FOR UNINSURED YOUNG ADULTS.

''(a) IN GENERAL.—A group health plan that provides coverage for dependent children shall make available such coverage, at the option of the participant involved, for one or more qualified children (as defined in subsection (b)) of the participant.

''(b) QUALIFIED CHILD DEFINED.—In this section, the term 'qualified child' means, with respect to a participant in a group health plan, an individual who (but for age) would be treated as a dependent child of the participant under such plan and who—

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

''(2) is not enrolled as a participant, beneficiary, or enrollee (other than under this section, section 704 of the Employee Retirement Income Security Act of 1974, or section 2704 or 2746 of the Public Health Service Act) under any health insurance coverage or group health plan.

''(c) PREMIUMS.—Nothing in this section shall be construed as preventing a group health plan from increasing the premiums otherwise required for coverage provided under this section consistent with standards established by the Secretary based upon family size.''.

(B) CLERICAL AMENDMENT.—The table of sections of such chapter is amended by inserting after the item relating to section 9803 the following:

''Sec. 9804. Requiring the option of extension of dependent coverage for uninsured young adults.''.

(b) INDIVIDUAL HEALTH INSURANCE COVERAGE.—Title XXVII of the Public Health Service Act is amended by inserting after section 2745 the following new section:

''SEC. 2746. REQUIRING THE OPTION OF EXTENSION OF DEPENDENT COVERAGE FOR UNINSURED YOUNG ADULTS.

''The provisions of section 2703 shall apply to health insurance coverage offered by a health insurance issuer in the individual market in the same manner as they apply to health insurance coverage offered by a health insurance issuer in connection with a group health plan in the small or large group market.''.

(c) EFFECTIVE DATES.—

(1) GROUP HEALTH PLANS.—The amendments made by subsection (a) shall apply to group health

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

(2) INDIVIDUAL HEALTH INSURANCE COVERAGE.—Section 2746 of the Public Health Service Act, as inserted by subsection (b), shall apply with respect to health insurance coverage offered, sold, issued, renewed, in effect, or operated in the individual market on or after January 1, 2010.

SEC. 106. LIMITATIONS ON PREEXISTING CONDITION EXCLUSIONS IN GROUP HEALTH PLANS IN ADVANCE OF APPLICABILITY OF NEW PROHIBITION OF PREEXISTING CONDITION EXCLUSIONS.

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

(1) REDUCTION IN LOOK-BACK PERIOD.—Section 701(a)(1) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1181(a)(1)) is amended by striking ''6-month period'' and inserting ''30-day period''.

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

and by striking ''18 months'' and inserting ''9 months''.

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

''(h) TERMINATION.—This section shall cease to apply to any group health plan as of the date that such plan becomes subject to the requirements of section 211 of the (relating to prohibiting preexisting condition exclusions).''.

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

(1) REDUCTION IN LOOK-BACK PERIOD.—Section 9801(a)(1) of the Internal Revenue Code of 1986 is amended by striking ''6-month period'' and inserting ''30-day period''.

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

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

''(g) TERMINATION.—This section shall cease to apply to any group health plan as of the date that such plan becomes subject to the requirements of section 211 of the (relating to prohibiting preexisting condition exclusions).''.

(c) AMENDMENTS TO PUBLIC HEALTH SERVICE ACT.—

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

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

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

''(h) TERMINATION.—This section shall cease to apply to any group health plan as of the date that such plan becomes subject to the requirements of section 211 of the (relating to prohibiting preexisting condition exclusions).''.

(4) MISCELLANEOUS TECHNICAL AMENDMENT.—Section 2702(a)(2) of such Act (42 U.S.C. 300gg–1) is amended by striking ''701'' and inserting ''2701''.

(d) EFFECTIVE DATE.—

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

(2) SPECIAL RULE FOR COLLECTIVE BARGAINING AGREEMENTS.—In the case of a group health plan maintained pursuant to 1 or more collective bargaining agreements between employee representatives and 1 or more employers ratified before the date of the enactment of this Act, the amendments made by this section shall not apply to plan years beginning before the earlier of—

(A) the date on which the last of the collective bargaining agreements relating to the plan terminates (determined without regard to any extension thereof agreed to after the date of the enactment of this Act);

(B) 3 years after the date of the enactment of this Act.

SEC. 107. PROHIBITING ACTS OF DOMESTIC VIOLENCE FROM BEING TREATED AS PREEXISTING CONDITIONS.

(a) ERISA.—Section 701(d)(3) of the Employee Retirement Income Security Act of 1974 (29 U.S.C.) is amended—

(1) in the heading, by inserting ''OR DOMESTIC VIOLENCE'' after ''PREGNANCY''; and

(2) by inserting ''or domestic violence'' after ''relating to pregnancy''.

(b) PHSA.—

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

(A) in the heading, by inserting ''OR DOMESTIC VIOLENCE'' after ''PREGNANCY''; and

(B) by inserting ''or domestic violence'' after ''relating to pregnancy''.

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

''SEC. 2754. PROHIBITION ON DOMESTIC VIOLENCE AS PREEXISTING CONDITION.

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

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

(c) IRC.—Section 9801(d)(3) of the Internal Revenue Code of 1986 is amended—

(1) in the heading, by inserting ''OR DOMESTIC VIOLENCE'' after ''PREGNANCY''; and

(2) by inserting ''or domestic violence'' after ''relating to pregnancy''.

(d) EFFECTIVE DATES.—

(1) Except as otherwise provided in this subsection, the amendments made by this section shall apply with respect to group health plans (and health insurance issuers offering group health insurance coverage) for plan years beginning on or after January 1, 2010.

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

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

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

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

"SEC. 715. STANDARDS RELATING TO BENEFITS FOR MINOR CHILD'S CONGENITAL OR DEVELOPMENTAL DEFORMITY OR DISORDER.

''(a) REQUIREMENTS FOR TREATMENT FOR CHILDREN WITH DEFORMITIES.—

''(1) IN GENERAL.—A group health plan, and a health insurance issuer offering group health insurance coverage, that provides coverage for surgical benefits shall provide coverage for outpatient and inpatient diagnosis and treatment of a minor child's congenital or developmental deformity, disease, or injury. A minor child shall include any individual who is 21 years of age or younger.

''(2) TREATMENT DEFINED.—

''(A) IN GENERAL.—In this section, the term 'treatment' includes reconstructive surgical procedures (procedures that are generally performed to improve function, but may also be performed to approximate a normal appearance) that are performed on abnormal structures of the body caused by congenital defects,

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

''(i) procedures that do not materially affect the function of the body part being treated; and

''(ii) procedures for secondary conditions and follow-up treatment.

''(B) EXCEPTION.—Such term does not include cosmetic surgery performed to reshape normal structures of the body to improve appearance or self-esteem.

''(b) NOTICE.—A group health plan under this part shall comply with the notice requirement under section 713(b) (other than paragraph (3)) with respect to the requirements of this section.''.

(2) CONFORMING AMENDMENT.—

(A) Subsection (c) of section 731 of such Act is amended by striking ''section 711'' and inserting ''sections 711 and 715''.

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

''Sec. 715. Standards relating to benefits for minor child's congenital or developmental deformity or disorder.''.

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

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

"SEC. 9814. STANDARDS RELATING TO BENEFITS FOR MINOR CHILD'S CONGENITAL OR DEVELOPMENTAL DEFORMITY OR DISORDER.

''(a) REQUIREMENTS FOR TREATMENT FOR CHILDREN WITH DEFORMITIES.—A group health plan that provides coverage for surgical benefits shall provide coverage for outpatient and inpatient diagnosis and treatment of a minor child's congenital or developmental deformity, disease, or injury. A minor child shall include any individual who is 21 years of age or younger.

''(b) TREATMENT DEFINED.—

''(1) IN GENERAL.—In this section, the term 'treatment' includes reconstructive surgical procedures (procedures that are generally performed to improve function, but may also be performed to approximate a normal appearance) that are performed on abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease, including—

''(A) procedures that do not materially affect the function of the body part being treated, and

''(B) procedures for secondary conditions and follow-up treatment.

''(2) EXCEPTION.—Such term does not include cosmetic surgery performed to reshape normal structures of the body to improve appearance or self-esteem.''.

(2) CLERICAL AMENDMENT.—The table of sections for subchapter B of chapter 100 of such Code is amended by adding at the end the following new item:

''Sec. 9814. Standards relating to benefits for minor child's congenital or developmental deformity or disorder.''.

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

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

''SEC. 2708. STANDARDS RELATING TO BENEFITS FOR MINOR CHILD'S CONGENITAL OR DEVELOPMENTAL DEFORMITY OR DISORDER.

''(a) REQUIREMENTS FOR TREATMENT FOR CHILDREN WITH DEFORMITIES.—

''(1) IN GENERAL.—A group health plan, and a health insurance issuer offering group health insurance coverage, that provides coverage for surgical benefits shall provide coverage for outpatient and in-

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

''(2) TREATMENT DEFINED.—

''(A) IN GENERAL.—In this section, the term 'treatment' includes reconstructive surgical procedures (procedures that are generally performed to improve function, but may also be performed to approximate a normal appearance) that are performed on abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease, including—

''(i) procedures that do not materially affect the function of the body part being treated; and

''(ii) procedures for secondary conditions and follow-up treatment.

''(B) EXCEPTION.—Such term does not include cosmetic surgery performed to reshape normal structures of the body to improve appearance or self-esteem.

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

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

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

''SEC. 2755. STANDARDS RELATING TO BENEFITS FOR MINOR CHILD'S CONGENITAL OR DEVELOPMENTAL DEFORMITY OR DISORDER.

''The provisions of section 2708 shall apply to health insurance coverage offered by a health insurance issuer in the individual market in the same manner as such provisions apply to health insurance coverage offered by a health insurance issuer in connection with a group health plan in the small or large group market.''.

(3) CONFORMING AMENDMENTS.—

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

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

''section 2751'' and inserting ''sections 2751 and 2755''.

(d) EFFECTIVE DATES.—

(1) The amendments made by this section shall apply with respect to group health plans (and health insurance issuers offering group health insurance coverage) for plan years beginning on or after January 1, 2010.

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

(e) COORDINATION.—Section 104(1) of the Health Insurance Portability and Accountability Act of 1996 is amended by striking ''(and the amendments made by this subtitle and section 401)'' and inserting '', part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974, parts A and C of title XXVII of the Public Health Service Act, and chapter 100 of the Internal Revenue Code of 1986''.

SEC. 109. ELIMINATION OF LIFETIME LIMITS.

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

(1) IN GENERAL.—Subpart B of part 7 of subtitle B of title I of the Employee Retirement Income

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

"SEC. 716. ELIMINATION OF LIFETIME AGGREGATE LIMITS.

''(a) IN GENERAL.—A group health plan and a health insurance issuer providing health insurance coverage in connection with a group health plan, may not impose an aggregate dollar lifetime limit with respect to benefits payable under the plan or coverage.

''(b) DEFINITION.—In this section, the term 'aggregate dollar lifetime limit' means, with respect to benefits under a group health plan or health insurance coverage offered in connection with a group health plan, a dollar limitation on the total amount that may be paid with respect to such benefits under the plan or health insurance coverage with respect to an individual or other coverage unit on a lifetime basis.''.

(2) CLERICAL AMENDMENT.—The table of contents in section 1 of such Act, is amended by inserting after the item relating to section 715 the following new item:

''Sec. 716. Elimination of lifetime aggregate limits.''.

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

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

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

"SEC. 9815. ELIMINATION OF LIFETIME AGGREGATE LIMITS.

"(a) IN GENERAL.—A group health plan may not impose an aggregate dollar lifetime limit with respect to benefits payable under the plan.

"(b) DEFINITION.—In this section, the term 'aggregate dollar lifetime limit' means, with respect to benefits under a group health plan a dollar limitation on the total amount that may be paid with respect to such benefits under the plan with respect to an individual or other coverage unit on a lifetime basis.".

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

"Sec. 9854. Standards relating to benefits for minor child's congenital or developmental deformity or disorder.".

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

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

"SEC. 2709. ELIMINATION OF LIFETIME AGGREGATE LIMITS.

"(a) IN GENERAL.—A group health plan and a health insurance issuer providing health insurance coverage in connection with a group health plan, may not impose an aggregate dollar lifetime limit with respect to benefits payable under the plan or coverage.

"(b) DEFINITION.—In this section, the term 'aggregate dollar lifetime limit' means, with respect to benefits under a group health plan or health insurance coverage, a dollar limitation on the total amount that may be paid with respect to such benefits under the plan or health insurance coverage with respect to an individual or other coverage unit on a lifetime basis.".

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

"SEC. 2756. ELIMINATION OF ANNUAL OR LIFETIME AGGREGATE LIMITS.

"The provisions of section 2709 shall apply to health insurance coverage offered by a health insurance issuer in the individual market in the same manner as they apply to health insurance coverage offered by a health insurance

issuer in connection with a group health plan in the small or large group market.''.

(d) EFFECTIVE DATES.—

(1) The amendments made by this section shall apply with respect to group health plans (and health insurance issuers offering group health insurance coverage) for plan years beginning on or after January 1, 2010.

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

SEC. 110. PROHIBITION AGAINST POSTRETIREMENT REDUCTIONS OF RETIREE HEALTH BENEFITS BY GROUP HEALTH PLANS.

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

''SEC. 717. PROTECTION AGAINST POSTRETIREMENT REDUCTION OF RETIREE HEALTH BENEFITS.

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

such participant, if such reduction affects the benefits provided to the participant or beneficiary as of the date the participant retired for purposes of the plan and such reduction occurs after the participant's retirement unless such reduction is also made with respect to active participants. Nothing in this section shall prohibit a plan from enforcing a total aggregate cap on amounts paid for retiree health coverage that is part of the plan at the time of retirement.

''(b) NO REDUCTION.—Notwithstanding that a group health plan may contain a provision reserving the general power to amend or terminate the plan or a provision specifically authorizing the plan to make post-retirement reductions in retiree health benefits, it shall be prohibited for any group health plan, whether through amendment or otherwise, to reduce the benefits provided to a retired participant or the participant's beneficiary under the terms of the plan if such reduction of benefits occurs after the date the participant retired for purposes of the plan and reduces benefits that were provided to the participant, or the participant's beneficiary, as of the date the participant retired unless such reduction is also made with respect to active participants.

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

''(1) with respect to premiums occurs under a group health plan when a participant's (or beneficiary's) share of the total premium (or, in the case of a self-insured plan, the costs of coverage) of the plan substantially increases; or

''(2) with respect to other cost-sharing and benefits under a group health plan occurs when there is a substantial decrease in the actuarial value of the benefit package under the plan.

For purposes of this section, the term 'substantial' means an increase in the total premium share or a decrease in the actuarial value of the benefit package that is greater than 5 percent.''

(b) CONFORMING AMENDMENT.—The table of contents in section 1 of such Act, as amended by sections 108 and 109, is amended by inserting after the item relating to section 716 the following new item:

''Sec. 717. Protection against postretirement reduction of retiree health benefits.''.

(c) WAIVER.—An employer may, in a form and manner which shall be prescribed by the Secretary of Labor, apply for a waiver from this provision if the employer can reasonably demonstrate that meeting the requirements of this section would impose an undue hardship on the employer.

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

SEC. 111. REINSURANCE PROGRAM FOR RETIREES.

(a) ESTABLISHMENT.—

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

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

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

(i) is —

(I) maintained by one or more employers (including without limitation any State or political subdivision thereof, or any agency or instrumentality of any of the foregoing), former

employers or employee organizations or associations, or a voluntary employees' beneficiary association, or a committee or board of individuals appointed to administer such plan; or

(II) a multiemployer plan (as defined in section 3(37) of the Employee Retirement Income Security Act of 1974); and

(ii) provides health benefits to retirees.

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

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

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

(i) is 55 years of age or older;

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

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

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

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

(c) PAYMENT.—

(1) SUBMISSION OF CLAIMS.—

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

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

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

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

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

(3) USE OF PAYMENTS.—Amounts paid to a participating employment-based plan under this subsection shall only be used to reduce the costs of health care provided by the plan by reducing premium costs for the employer or employee association maintaining the plan, and reducing premium contributions, deductibles, copayments, coinsurance, or other out-of-pocket costs for plan participants and beneficiaries. Where the benefits are provided by an employer to members of a represented bargaining unit, the allocation of payments among these purposes shall be subject to collective bargaining. Amounts paid to the plan under this subsection shall not be used as general revenues by the employer or employee association maintaining the plan or for any other purposes. The Secretary shall develop a mechanism to monitor the appropriate use of such payments by such plans.

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

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

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

(5) AUDITS.—The Secretary shall conduct annual audits of claims data submitted by participating employment-based plans under this section to ensure that they are in compliance with the requirements of this section.

(d) RETIREE RESERVE TRUST FUND.—

(1) ESTABLISHMENT.—

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

(B) FUNDING.—There are hereby appropriated to the Trust Fund, out of any moneys

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

(C) APPROPRIATIONS FROM THE TRUST FUND.—

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

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

SEC. 112. WELLNESS PROGRAM GRANTS.

(a) ALLOWANCE OF GRANT.—

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

Labor shall jointly award wellness grants as determined under this section. Wellness program grants shall be awarded to small employers (as defined by the Secretary) for any plan year in an amount equal to 50 percent of the costs paid or incurred by such employers in connection with a qualified wellness program during the plan year. For purposes of the preceding sentence, in the case of any qualified wellness program offered as part of an employment-based health plan, only costs attributable to the qualified wellness program and not to the health plan, or health insurance coverage offered in connection with such a plan, may be taken into account.

(2) LIMITATIONS.—

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

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

(i) the product of $150 and the number of employees of the employer for any plan year; and

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

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

(1) QUALIFIED WELLNESS PROGRAM.—The term ''qualified wellness program'' means a program that —

(A) includes any 3 wellness components described in subsection (c); and

(B) is to be certified jointly by the Secretary of Health and Human Services and the Secretary of Labor, in coordination with the Director of the Centers for Disease Control and Prevention, as a qualified wellness program under this section.

(2) PROGRAMS MUST BE CONSISTENT WITH RESEARCH AND BEST PRACTICES.—

(A) IN GENERAL.—The Secretary of Health and Human Services and the Secretary of Labor shall not certify a program as a qualified wellness program unless the program—

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

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

and emerging research and careful scientific reviews, including the Guide to Community Preventative Services, the Guide to Clinical Preventative Services, and the National Registry for Effective Programs, and

(iii) includes strategies which focus on prevention and support for employee populations at risk of poor health outcomes.

(B) PERIODIC UPDATING AND REVIEW.—The Secretaries of Health and Human Services and Labor, in consultation with other appropriate agencies shall jointly establish procedures for periodic review, evaluation, and update of the programs under this subsection.

(3) HEALTH LITERACY AND ACCESSIBILITY.—The Secretaries of Health and Human Services and Labor shall jointly, as part of the certification process—

(A) ensure that employers make the programs culturally competent, physically and programmatically accessible (including for individuals with disabilities), and appropriate to the health literacy needs of the employees covered by the programs;

(B) require a health literacy component to provide special assistance and materials to employees with low literacy skills, limited English and from underserved populations; and

(C) require the Secretaries to compile and disseminate to employer health plans information on model health literacy curricula, instructional programs, and effective intervention strategies.

(c) WELLNESS PROGRAM COMPONENTS.—For purposes of this section, the wellness program components described in this subsection are the following:

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

(A) HEALTH EDUCATION.—The dissemination of health information which addresses the specific needs and health risks of employees.

(B) HEALTH SCREENINGS.—The opportunity for periodic screenings for health problems and referrals for appropriate follow-up measures.

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

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

(3) BEHAVIORAL CHANGE COMPONENT.—A behavioral change component which encourages healthy living through counseling, seminars, on-line programs, self-help materials, or other programs which provide technical assistance and problem solving skills. Such component may include programs relating to—

(A) tobacco use;

(B) obesity;

(C) stress management;

(D) physical fitness;

(E) nutrition;

(F) substance abuse;

(G) depression; and

(H) mental health promotion.

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

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

(i) tobacco use at the worksite;

(ii) the nutrition of food available at the worksite through cafeterias and vending options;

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

(iv) the encouragement of physical activity before, during, and after work hours.

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

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

(2) shall not mandate participation by employees; and

(3) may provide a financial reward for participation of an individual in such program so long as such reward is not tied to the premium or cost-sharing of the individual under the health benefits plan.

(e) PRIVACY PROTECTIONS.—Data gathered for purposes of the employer wellness program may be used solely

for the purposes of administering the program. The Secretaries of Health and Human Services and Labor shall develop standards to ensure such data remain confidential and are not used for purposes beyond those for administering the program.

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

(g) OUTREACH.—The Secretaries of Health and Human Services and Labor, in conjunction with other appropriate agencies and members of the business community, shall jointly institute an outreach program to inform businesses about the availability of the wellness program grant as well as to educate businesses on how to develop programs according to recognized and promising practices and on how to measure the success of implemented programs.

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

(i) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as are necessary to carry out this section.

SEC. 113. EXTENSION OF COBRA CONTINUATION COVERAGE.

(a) EXTENSION OF CURRENT PERIODS OF CONTINUATION COVERAGE.—

(1) IN GENERAL.—In the case of any individual who is, under a COBRA continuation coverage provision, covered under COBRA continuation coverage on or after the date of the enactment of this Act, the required period of any such coverage which has not subsequently terminated under the terms of such provision for any reason other than the expiration of a period of a specified number of months shall, notwithstanding such provision and subject to subsection (b), extend to the earlier of the date on which such individual becomes eligible for acceptable coverage or the date on which such individual becomes eligible for health insurance coverage through the Health Insurance Exchange (or a State-based Health Insurance Exchange operating in a State or group of States).

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

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

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

(c) ACCESS TO STATE HEALTH BENEFITS RISK POOLS.—This section shall supersede any provision of the law of a State or political subdivision thereof to the extent that such provision has the effect of limiting or precluding access by a qualified beneficiary whose COBRA continuation coverage has been extended under this section to a State health benefits risk pool recognized by the Commissioner for purposes of this section solely by reason of the extension of such coverage beyond the date on which such coverage otherwise would have expired.

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

(1) COBRA CONTINUATION COVERAGE.—The term ''COBRA continuation coverage'' means continuation coverage provided pursuant to part 6 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (other than under section 609), title XXII of the Public Health Service Act, section 4980B of the Internal Revenue Code of 1986 (other than subsection (f)(1) of such section insofar as it relates to pediatric vaccines), or section 905a of title 5, United States Code, or under a State program that provides comparable continuation coverage. Such term does not include coverage under a health flexible spending arrangement under a cafeteria plan within the meaning of section 125 of the Internal Revenue Code of 1986.

(2) COBRA CONTINUATION PROVISION.—The term ''COBRA continuation provision'' means the provisions of law described in paragraph (1).

SEC. 114. STATE HEALTH ACCESS PROGRAM GRANTS.

(a) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall provide grants to States (as defined for purposes of title XIX of the Social Security Act) to establish programs to expand access to affordable health care coverage for the uninsured populations in that State in a

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

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

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

(2) COMMUNITY COVERAGE PROGRAM.—Community coverage with shared responsibility between employers, governmental or nonprofit entity, and the individual.

(3) REINSURANCE PLAN PROGRAM.—Reinsurance plans that subsidize a certain share of carrier losses within a certain risk corridor health insurance premium assistance.

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

(5) AUTOMATED ENROLLMENT PROGRAM.—Statewide or automated enrollment systems for public assistance programs.

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

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

(c) ELIGIBILITY AND ADMINISTRATION.—

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

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

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

(2) INELIGIBILITY.—A State that has already developed a comprehensive health insurance access program is not eligible for a grant under this section.

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

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

(4) ADMINISTRATION BASED ON CURRENT PROGRAM.—The program under this section is intended to build on the State Health Access Program funded under the Omnibus Appropriations Act, 2009 (Public Law 111–8).

(d) FUNDING LIMITATIONS.—

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

(A) only be available for expenditures before Y1; and

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

(2) MATCHING FUND REQUIREMENT.—

(A) IN GENERAL.—Subject to subparagraph (B), no grant may be awarded to a State unless the State demonstrates the seriousness of its effort by matching at least 20 percent of the grant amount through non-Federal resources, which may be a combination of State, local, private dollars from insurers, providers, and other private organizations.

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

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

(e) STUDY.—The Secretary shall review, study, and benchmark the progress and results of the programs funded under this section.

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

(g) FUNDING.—There are authorized to be appropriated such sums as may be necessary to carry out this section.

SEC. 115. ADMINISTRATIVE SIMPLIFICATION.

(a) STANDARDIZING ELECTRONIC ADMINISTRATIVE TRANSACTIONS.—

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

"SEC. 1173A. STANDARDIZE ELECTRONIC ADMINISTRATIVE TRANSACTIONS.

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

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

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

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

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

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

''(D) enable the real-time (or near real-time) determination of an individual's financial responsibility at the point of service and, to the extent possible, prior to service, including whether the individual is eligible for a specific service with a specific physician at a specific facility, on a specific date or range of dates, include utilization of a machine-readable health

plan beneficiary identification card or similar mechanism;

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

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

''(G) describe all data elements (such as reason and remark codes) in unambiguous terms, not permit optional fields, require that data elements be either required or conditioned upon set values in other fields, and prohibit additional conditions except where required by (or to implement) State or Federal law or to protect against fraud and abuse; and

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

''(3) TIME FOR ADOPTION.—Not later than 2 years after the date of the enactment of this section, the Secretary shall adopt standards under this section by interim, final rule.

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

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

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

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

''(D) require timely and transparent claim and denial management processes, including uniform claim edits, uniform reason and remark denial codes, tracking, adjudication, and appeal processing;

''(E) require the use of a standard electronic transaction with which health care providers may quickly and efficiently enroll with a

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

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

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

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

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

''(B) a proposal for accommodating necessary changes between version changes and a process for upgrading standards as often as annually by interim, final rulemaking;

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

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

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

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

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

and clearinghouses are both syntactically and functionally compliant with all the standard transactions mandated pursuant to the administrative simplification provisions of this part and the Health Insurance Portability and Accountability Act of 1996.

''(b) LIMITATIONS ON USE OF DATA.—Nothing in this section shall be construed to permit the use of information collected under this section in a manner that would violate State or Federal law.

''(c) PROTECTION OF DATA.—The Secretary shall ensure (through the promulgation of regulations or otherwise) that all data collected pursuant to subsection (a) are used and disclosed in a manner that meets the HIPAA privacy and security law (as defined in section 3009(a)(2) of the Public Health Service Act), including any privacy or security standard adopted under section 3004 of such Act.

''SEC. 1173B. INTERIM COMPANION GUIDES, INCLUDING OPERATING RULES.

''(a) IN GENERAL.—The Secretary shall adopt a single, binding, comprehensive companion guide, that includes operating rules for each X12 Version 5010 transaction described in section 1173(a)(2), to be effective until the new version of these transactions which comply with section 1173A are adopted and implemented.

''(b) COMPANION GUIDE AND OPERATING RULES DEVELOPMENT.—In adopting such interim companion guide and rules, the Secretary shall comply with section 1172, except that a nonprofit entity that meets the following criteria shall also be consulted:

''(1) The entity focuses its mission on administrative simplification.

''(2) The entity uses a multistakeholder process that creates consensus-based companion guides, including operating rules using a voting process that ensures balanced representation by the critical stakeholders (including health plans and health care providers) so that no one group dominates the entity and shall include others such as standards development organizations, and relevant Federal or State agencies.

''(3) The entity has in place a public set of guiding principles that ensure the companion guide and operating rules and process are open and transparent.

''(4) The entity coordinates its activities with the HIT Policy Committee, and the HIT Standards Committee (established under title XXX of the Public Health Service Act) and complements the efforts

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

''(5) The entity incorporates the standards issued under Health Insurance Portability and Accountability Act of 1996 and this part, and in developing the companion guide and operating rules does not change the definition, data condition or use of a data element or segment in a standard, add any elements or segments to the maximum defined data set, use any codes or data elements that are either marked 'not used' in the standard's implementation specifications or are not in the standard's implementation specifications, or change the meaning or intent of the standard's implementation specifications.

''(6) The entity uses existing market research and proven best practices.

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

''(8) The entity supports nondiscrimination and conflict of interest policies that demonstrate a commitment to open, fair, and nondiscriminatory practices.

''(9) The entity allows for public reviews and comment on updates of the companion guide, including the operating rules.

''(c) IMPLEMENTATION.—The Secretary shall adopt a single, binding companion guide, including operating rules under this section, for each transaction, to become effective with the X12 Version 5010 transaction implementation, or as soon thereafter as feasible. The companion guide, including operating rules for the transactions for eligibility for health plan and health claims status under this section shall be adopted not later than October 1, 2011, in a manner such that such set of rules is effective beginning not later than January 1, 2013. The companion guide, including operating rules for the remainder of the transactions described in section 1173(a)(2) shall be adopted not later than October 1, 2012, in a manner such that such set of rules is effective beginning not later than January 1, 2014.''.

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

(A) in paragraph (1), by inserting '', and associated operational guidelines and instructions, as determined appropriate by the Secretary'' after ''medical procedure codes''; and

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

''(10) OPERATING RULES.—The term 'operating rules' means business rules for using and processing transactions, such as service level requirements, which do not impact the implementation specifications or other data content requirements.''.

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

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

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

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

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

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

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

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

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

(B) COMPLIANCE DATE.—The amendments made by subparagraph (A) shall apply to transactions occurring on or after such date (not later than January 1, 2014) as the Secretary of Health and Human Services shall specify.

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

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

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

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

(1) in paragraph (23), by striking ''or'' at the end;

(2) in paragraph (24), by striking the period and inserting ''; or''; and

(3) by inserting after paragraph (24) the following new paragraph:

''(25) subject to subsection (h), not later than January 1, 2015, for which the payment is other than by electronic funds transfer (EFT) so long as the Secretary has adopted and implemented a standard for electronic funds transfer under section 1173A.''.

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

''(e) EXPANSION OF PENALTY AUTHORITY.—The Secretary may, in addition to the penalties provided under

subsections (a) and (b), provide for the imposition of penalties for violations of this part that are comparable—

''(1) in the case of health plans, to the sanctions the Secretary is authorized to impose under part C or D of title XVIII in the case of a plan that violates a provision of such part; or

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

TITLE II—PROTECTIONS AND STANDARDS FOR QUALIFIED HEALTH BENEFITS PLANS

Subtitle A—General Standards

SEC. 201. REQUIREMENTS REFORMING HEALTH INSURANCE MARKETPLACE.

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

(b) REQUIREMENTS FOR QUALIFIED HEALTH BENEFITS PLANS.—On or after the first day of Y1, a health benefits plan shall not be a qualified health benefits plan

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

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

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

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

(c) TERMINOLOGY.—In this division:

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

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

SEC. 202. PROTECTING THE CHOICE TO KEEP CURRENT COVERAGE.

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

(1) LIMITATION ON NEW ENROLLMENT.—

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

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

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

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

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

(1) GRACE PERIOD.—

(A) IN GENERAL.—The Commissioner shall establish a grace period whereby, for plan years beginning after the end of the 5-year period beginning with Y1, an employment-based health plan in operation as of the day before the first day of Y1 must meet the same requirements as apply to a qualified health benefits plan under section 201, including the essential benefit package requirement under section 221.

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

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

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

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

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

(2) TRANSITIONAL TREATMENT AS ACCEPTABLE COVERAGE.—During the grace period specified in paragraph (1)(A), an employment-based health plan (which may be a high deducible health plan, as defined in section 223(c)(2) of the Internal Revenue Code of 1986) that is described in such paragraph shall be treated as acceptable coverage under this division.

(c) LIMITATION ON INDIVIDUAL HEALTH INSURANCE COVERAGE.—

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

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

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

(B) this division shall be construed—

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

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

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

Subtitle B—Standards Guaranteeing Access to Affordable Coverage

SEC. 211. PROHIBITING PREEXISTING CONDITION EXCLUSIONS.

A qualified health benefits plan may not impose any preexisting 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 of the following: health status, medical condition, claims experience, receipt of health care, medical history, genetic information, evidence of insurability, disability, or source of injury (including conditions arising out of acts of domestic violence) or any similar factors.

SEC. 212. GUARANTEED ISSUE AND RENEWAL FOR INSURED PLANS AND PROHIBITING RESCISSIONS.

The requirements of sections 2711 (other than subsections (e) and (f)) 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 non-payment of premiums and there is a grace period during which the enrollee has an opportunity to correct such non-payment. Rescissions of such coverage shall be prohibited except in cases of fraud as defined in section 2712(b)(2) of such Act.

SEC. 213. INSURANCE RATING RULES.

(a) IN GENERAL.—The premium rate charged for a qualified health benefits plan that is health insurance coverage may not vary except as follows:

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

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

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

(b) ACTUARIAL VALUE OF OPTIONAL SERVICE COVERAGE.—

(1) IN GENERAL.—The Commissioner shall estimate the basic per enrollee, per month cost, determined on an average actuarial basis, for including coverage under a basic plan of the services described in section 222(d)(4)(A).

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

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

cluding prenatal care, delivery, or postnatal care;

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

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

(c) STUDY AND REPORTS.—

(1) STUDY.—The Commissioner, in coordination with the Secretary of Health and Human Services and the Secretary of Labor, shall conduct a study of the large-group-insured and self-insured employer health care markets. Such study shall examine the following:

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

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

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

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

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

(2) REPORTS.—Not later than 18 months after the date of the enactment of this Act, the Commissioner shall submit to Congress and the applicable agencies a report on the study conducted under paragraph (1). Such report shall include any recommendations the Commissioner deems appropriate to ensure that the law does not provide incentives for small and midsize employers to self-insure or create adverse selection in the risk pools of large group insurers and self-insured employers. Not later than 18 months after the first day of Y1, the Commissioner shall submit to Congress and the applicable agencies an updated report on such study, including updates on such recommendations.

SEC. 214. NONDISCRIMINATION IN BENEFITS; PARITY IN MENTAL HEALTH AND SUBSTANCE ABUSE DISORDER BENEFITS.

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

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

SEC. 215. ENSURING ADEQUACY OF PROVIDER NETWORKS.

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

and services and transparency in the cost-sharing differentials among providers participating in the network and policies for accessing out-of-network providers.

(b) INTERNET ACCESS TO INFORMATION.—A qualified health benefits plan that uses a provider network shall provide a current listing of all providers in its network on its Website and such data shall be available on the Health Insurance Exchange Website as a part of the basic information on that plan. The Commissioner shall also establish an on-line system whereby an individual may select by name any medical provider (as defined by the Commissioner) and be informed of the plan or plans with which that provider is contracting.

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

SEC. 216. REQUIRING THE OPTION OF EXTENSION OF DEPENDENT COVERAGE FOR UNINSURED YOUNG ADULTS.

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

(b) QUALIFIED CHILD DEFINED.—In this section, the term ''qualified child'' means, with respect to a principal enrollee in a qualified health benefits plan, an individual who (but for age) would be treated as a dependent child of the enrollee under such plan and who—

(1) is under 27 years of age; and

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

(c) PREMIUMS.—Nothing in this section shall be construed as preventing a qualified health benefits plan from increasing the premiums otherwise required for coverage provided under this section consistent with standards established by the Commissioner based upon family size under section 213(a)(3).

SEC. 217. CONSISTENCY OF COSTS AND COVERAGE UNDER QUALIFIED HEALTH BENEFITS PLANS DURING PLAN YEAR.

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

Subtitle C—Standards Guaranteeing Access to Essential Benefits

SEC. 221. COVERAGE OF ESSENTIAL BENEFITS PACKAGE.

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

(b) CHOICE OF COVERAGE.—

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

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

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

outside of the Health Insurance Exchange and under State law of health benefits in the form of excepted benefits (described in section 202(b)(1)(B)(ii)) if such benefits are offered under a separate policy, contract, or certificate of insurance.

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

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

SEC. 222. ESSENTIAL BENEFITS PACKAGE DEFINED.

(a) IN GENERAL.—In this division, the term ''essential benefits package'' means health benefits coverage, consistent with standards adopted under section 224, to ensure the provision of quality health care and financial security, that—

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

erally accepted standards of medical or other appropriate clinical or professional practice;

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

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

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

(5) is equivalent in its scope of benefits, as certified by Office of the Actuary of the Centers for Medicare & Medicaid Services, to the average prevailing employer-sponsored coverage in Y1.

In order to carry out paragraph (5), the Secretary of Labor shall conduct a survey of employer-sponsored coverage to determine the benefits typically covered by employers, including multiemployer plans, and provide a report on such survey to the Health Benefits Advisory Committee and to the Secretary of Health and Human Services.

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

(1) Hospitalization.

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

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

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

(5) Prescription drugs.

(6) Rehabilitative and habilitative services.

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

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

(9) Maternity care.

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

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

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

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

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

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

(2) ANNUAL LIMITATION.—

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

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

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

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

(3) MINIMUM ACTUARIAL VALUE.—

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

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

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

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

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

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

(3) COVERAGE UNDER PUBLIC HEALTH INSURANCE OPTION.—The public health insurance option shall provide coverage for services described in paragraph (4)(B). Nothing in this Act shall be construed as preventing the public health insurance option from providing for or prohibiting coverage of services described in paragraph (4)(A).

(4) ABORTION SERVICES.—

(A) ABORTIONS FOR WHICH PUBLIC FUNDING IS PROHIBITED.—The services described in this subparagraph are abortions for which the expenditure of Federal funds appropriated for the Department of Health and Human Services is not permitted, based on the law as in effect as of the date that is 6 months before the beginning of the plan year involved.

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

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

SEC. 223. HEALTH BENEFITS ADVISORY COMMITTEE.

(a) ESTABLISHMENT.—

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

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

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

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

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

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

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

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

(5) PARTICIPATION.—The membership of the Health Benefits Advisory Committee shall at least reflect providers, patient representatives, employers (including small employers), labor, health insurance issuers, experts in health care financing and delivery, experts in oral health care, experts in racial and

ethnic disparities, experts on health care needs and disparities of individuals with disabilities, representatives of relevant governmental agencies, and at least one practicing physician or other health professional and an expert in child and adolescent health and shall represent a balance among various sectors of the health care system so that no single sector unduly influences the recommendations of such Committee.

(b) DUTIES.—

(1) RECOMMENDATIONS ON BENEFIT STANDARDS.—The Health Benefits Advisory Committee shall recommend to the Secretary of Health and Human Services (in this subtitle referred to as the ''Secretary'') benefit standards (as defined in paragraph (5)), and periodic updates to such standards. In developing such recommendations, the Committee shall take into account innovation in health care and consider how such standards could reduce health disparities.

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

(3) STATE INPUT.—The Health Benefits Advisory Committee shall examine the health coverage laws and benefits of each State in developing recommendations under this subsection and may incorporate such coverage and benefits as the Committee determines to be appropriate and consistent with this Act. The Health Benefits Advisory Committee shall also seek input from the States and consider recommendations on how to ensure quality of health coverage in all States.

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

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

(A) the essential benefits package described in section 222, including categories of covered treatments, items and services within benefit classes, and cost-sharing consistent with subsection (d) of such section; and

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

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

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

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

(c) OPERATIONS.—

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

(2) MEMBERS NOT TREATED AS FEDERAL EMPLOYEES.—Members of the Health Benefits Advi-

sory Committee shall not be considered employees of the Federal Government solely by reason of any service on the Committee, except such members shall be considered to be within the meaning of section 202(a) of title 18, United States Code, for the purposes of disclosure and management of conflicts of interest.

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

(d) PUBLICATION.—The Secretary shall provide for publication in the Federal Register and the posting on the Internet Website of the Department of Health and Human Services of all recommendations made by the Health Benefits Advisory Committee under this section.

SEC. 224. PROCESS FOR ADOPTION OF RECOMMENDATIONS; ADOPTION OF BENEFIT STANDARDS.

(a) PROCESS FOR ADOPTION OF RECOMMENDATIONS.—

(1) REVIEW OF RECOMMENDED STANDARDS.—Not later than 45 days after the date of receipt of benefit standards recommended under section 223 (including such standards as modified under paragraph (2)(B)), the Secretary shall review such

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

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

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

(B) not to propose adoption of such standards as a package, the Secretary shall notify the Health Benefits Advisory Committee in writing of such determination and the reasons for not proposing the adoption of such recommendation and provide the Committee with a further opportunity to modify its previous recommendations and submit new recommendations to the Secretary on a timely basis.

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

propose adoption of initial benefit standards by such deadline.

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

(b) ADOPTION OF STANDARDS.—

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

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

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

Subtitle D—Additional Consumer Protections

SEC. 231. REQUIRING FAIR MARKETING PRACTICES BY HEALTH INSURERS.

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

SEC. 232. REQUIRING FAIR GRIEVANCE AND APPEALS MECHANISMS.

(a) IN GENERAL.—A QHBP offering entity shall provide for timely grievance and appeals mechanisms with respect to qualified health benefits plans that the Commissioner shall establish consistent with this section. The Commissioner shall establish time limits for each of such mechanisms and implement them in a manner that is protective to the needs of patients.

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

(e) 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 251.

SEC. 233. REQUIRING INFORMATION TRANSPARENCY AND PLAN DISCLOSURE.

(a) ACCURATE AND TIMELY DISCLOSURE.—

(1) FOR EXCHANGE-PARTICIPATING HEALTH BENEFITS PLANS.—A QHBP offering entity offering an Exchange-participating health benefits plan shall comply with standards established by the Commissioner for the accurate and timely disclosure to the Commissioner and the public of plan documents, plan terms and conditions, claims payment policies and practices, periodic financial disclosure, data on enrollment, data on disenrollment, data on the number of claims denials, data on rating practices, information on cost-sharing and payments with respect to any out-of-network coverage, and other information as determined appropriate by the Commissioner.

(2) EMPLOYMENT-BASED HEALTH PLANS.—The Secretary of Labor shall update and harmonize the Secretary's rules concerning the accurate and timely disclosure to participants by group health plans of plan disclosure, plan terms and conditions, and periodic financial disclosure with the standards established by the Commissioner under paragraph (1).

(3) USE OF PLAIN LANGUAGE.—

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

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

(C) GUIDANCE.—The Commissioner and the Secretary of Labor shall jointly develop and issue guidance on best practices of plain language writing.

(4) INFORMATION ON RIGHTS.—The information disclosed under this subsection shall include information on enrollee and participant rights under this division.

(5) COST-SHARING TRANSPARENCY.—A qualified health benefits plan shall allow individuals to learn the amount of cost-sharing (including deductibles, copayments, and coinsurance) under the individual's plan or coverage that the individual would be responsible for paying with respect to the furnishing of a specific item or service by a participating provider in a timely manner upon request. At a minimum, this information shall be made available

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

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

(c) PHARMACY BENEFIT MANAGERS TRANSPARENCY REQUIREMENTS.—

(1) IN GENERAL.—If a QHBP offering entity contracts with a pharmacy benefit manager or other entity (in this subsection referred to as a ''PBM'') to manage prescription drug coverage or otherwise control prescription drug costs under a qualified health benefits plan, the PBM shall provide at least annually to the Commissioner and to the QHBP offering entity offering such plan the following information, in a form and manner to be determined by the Commissioner:

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

(B) An estimate of aggregate average payments under the contract, per prescription (weighted by prescription volume), made to mail

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

(C) An estimate of the aggregate average payment per prescription (weighted by prescription volume) under the contract received from pharmaceutical manufacturers, including all rebates, discounts, prices concessions, or administrative, and other payments from pharmaceutical manufacturers, and a description of the types of payments, and the amount of these payments that were shared with the plan, and a description of the percentage of prescriptions for which the PBM received such payments.

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

(E) Information on the percentage and number of cases under the contract in which individuals were switched because of PBM policies or at the direct or indirect control of the PBM from a prescribed drug that had a lower

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

(2) CONFIDENTIALITY OF INFORMATION.—Information disclosed by a PBM to the Commissioner or a QHBP offering entity under this subsection is confidential and shall not be disclosed by the Commissioner or the QHBP offering entity in a form which discloses the identity of a specific PBM or prices charged by such PBM or a specific retailer, manufacturer, or wholesaler, except only by the Commissioner—

(A) to permit State or Federal law enforcement authorities to use the information provided for program compliance purposes and for the purpose of combating waste, fraud, and abuse;

(B) to permit the Comptroller General, the Medicare Payment Advisory Commission, or the Secretary of Health and Human Services to review the information provided; and

(C) to permit the Director of the Congressional Budget Office to review the information provided.

(3) ANNUAL PUBLIC REPORT.—On an annual basis, the Commissioner shall prepare a public report providing industrywide aggregate or average information to be used in assessing the overall impact of PBMs on prescription drug prices and spending. Such report shall not disclose the identity of a specific PBM, or prices charged by such PBM, or a specific retailer, manufacturer, or wholesaler, or any other confidential or trade secret information.

(4) PENALTIES.—The provisions of subsection (b)(3)(C) of section 1927 shall apply to a PBM that fails to provide information required under subsection (a) or that knowingly provides false information in the same manner as such provisions apply to a manufacturer with an agreement under such section that fails to provide information under subsection (b)(3)(A) of such section or knowingly provides false information under such section, respectively.

SEC. 234. APPLICATION TO QUALIFIED HEALTH BENEFITS PLANS NOT OFFERED THROUGH THE HEALTH INSURANCE EXCHANGE.

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

SEC. 235. TIMELY PAYMENT OF CLAIMS.

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

SEC. 236. STANDARDIZED RULES FOR COORDINATION AND SUBROGATION OF BENEFITS.

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

SEC. 237. APPLICATION OF ADMINISTRATIVE SIMPLIFICATION.

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

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

SEC. 238. STATE PROHIBITIONS ON DISCRIMINATION AGAINST HEALTH CARE PROVIDERS.

This Act (and the amendments made by this Act) shall not be construed as superseding laws, as they now or hereinafter exist, of any State or jurisdiction designed to prohibit a qualified health benefits plan from discriminating with respect to participation, reimbursement, covered services, indemnification, or related requirements under such plan against a health care provider that is acting within the scope of that provider's license or certification under applicable State law.

SEC. 239. PROTECTION OF PHYSICIAN PRESCRIBER INFORMATION.

(a) STUDY.—The Secretary of Health and Human Services shall conduct a study on the use of physician prescriber information in sales and marketing practices of pharmaceutical manufacturers.

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

SEC. 240. DISSEMINATION OF ADVANCE CARE PLANNING INFORMATION.

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

(1) shall provide for the dissemination of information related to end-of-life planning to individuals seeking enrollment in Exchange-participating health benefits plans offered through the Exchange;

(2) shall present such individuals with—

(A) the option to establish advanced directives and physician's orders for life sustaining treatment according to the laws of the State in which the individual resides; and

(B) information related to other planning tools; and

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

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

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

(1) to require an individual to complete an advanced directive or a physician's order for life sustaining treatment or other end-of-life planning document;

(2) to require an individual to consent to restrictions on the amount, duration, or scope of medical benefits otherwise covered under a qualified health benefits plan; or

(3) to promote suicide, assisted suicide, euthanasia, or mercy killing.

(c) ADVANCED DIRECTIVE DEFINED.—In this section, the term ''advanced directive'' includes a living will, a comfort care order, or a durable power of attorney for health care.

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

(1) IN GENERAL.—Subject to paragraph (3), information provided to meet the requirements of subsection (a)(2) shall not include advanced directives or other planning tools that list or describe as an option suicide, assisted suicide, euthanasia, or mercy killing, regardless of legality.

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

(A) withhold or withdraw of medical treatment or medical care;

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

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

(3) NO PREEMPTION OF STATE LAW.—Nothing in this section shall be construed to preempt or otherwise have any effect on State laws regarding advance care planning, palliative care, or end-of-life decision-making.

Subtitle E—Governance

SEC. 241. HEALTH CHOICES ADMINISTRATION; HEALTH CHOICES COMMISSIONER.

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

(b) COMMISSIONER.—

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

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

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

(c) INSPECTOR GENERAL.—For provision establishing an Office of the Inspector General for the Health Choices Administration, see section 1647.

SEC. 242. DUTIES AND AUTHORITY OF COMMISSIONER.

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

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

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

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

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

(b) PROMOTING ACCOUNTABILITY.—

(1) IN GENERAL.—The Commissioner shall undertake activities in accordance with this subtitle to promote accountability of QHBP offering entities in meeting Federal health insurance requirements, regardless of whether such accountability is with respect to qualified health benefits plans offered through the Health Insurance Exchange or outside of such Exchange.

(2) COMPLIANCE EXAMINATION AND AUDITS.—

(A) IN GENERAL.—The Commissioner shall, in coordination with States, conduct audits of qualified health benefits plan compliance with Federal requirements. Such audits may include random compliance audits and targeted

audits in response to complaints or other suspected noncompliance.

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

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

(d) SANCTIONS AUTHORITY.—

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

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

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

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

(C) in the case of an Exchange-participating health benefits plan, suspension of payment to the entity under the Health Insurance Exchange for individuals enrolled in such plan after the date the Commissioner notifies the entity of a determination under paragraph (1) and until the Secretary is satisfied that the basis for such determination has been corrected and is not likely to recur; or

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

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

(f) EFFICIENCY IN ADMINISTRATION.—The Commissioner shall issue regulations for the effective and efficient administration of the Health Insurance Exchange and affordability credits under subtitle C, including, with respect to the determination of eligibility for affordability credits, the use of personnel who are employed in accordance with the requirements of title 5, United States Code, to carry out the duties of the Commissioner or, in the case of sections 308 and 341(b)(2), the use of State personnel who are employed in accordance with standards prescribed by the Office of Personnel Management pursuant to section 208 of the Intergovernmental Personnel Act of 1970 (42 U.S.C. 4728).

SEC. 243. CONSULTATION AND COORDINATION.

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

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

benefits plan under this title and enforcement of such standards.

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

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

(4) The Federal Trade Commission, specifically concerning the development and issuance of guidance, rules, or standards regarding fair marketing practices under section 231 or otherwise, or any consumer disclosure requirements under section 233 or otherwise.

(5) Other appropriate Federal agencies.

(6) Indian tribes and tribal organizations.

(b) COORDINATION.—

(1) IN GENERAL.—In carrying out the functions of the Commissioner, including with respect to the enforcement of the provisions of this division, the Commissioner shall work in coordination with

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

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

SEC. 244. HEALTH INSURANCE OMBUDSMAN.

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

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

(1) receive complaints, grievances, and requests for information submitted by individuals through means such as the mail, by telephone, electronically, and in person;

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

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

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

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

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

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

Subtitle F—Relation to Other Requirements; Miscellaneous

SEC. 251. 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 paragraphs (1) or (2) shall be construed as affecting the application of section 514 of the Employee Retirement Income Security Act of 1974.

(b) COVERAGE OFFERED THROUGH EXCHANGE.—

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

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

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

(2) CONSTRUCTION.—In the case of coverage described in paragraph (1), nothing in such paragraph shall be construed as preventing the application of rights and remedies under State laws to health insurance issuers generally with respect to any requirement referred to in paragraph (1)(A). The previous sentence shall not be construed as providing for the applicability of rights or remedies under State laws with respect to requirements applicable to employers or other plan sponsors in connection with arrangements which are treated as group

health plans under section 802(a)(1) of the Employee Retirement Income Security Act of 1974.

SEC. 252. PROHIBITING DISCRIMINATION IN HEALTH CARE.

(a) IN GENERAL.—Except as otherwise explicitly permitted by this Act and by subsequent regulations consistent with this Act, all health care and related services (including insurance coverage and public health activities) covered by this Act shall be provided without regard to personal characteristics extraneous to the provision of high quality health care or related services.

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

SEC. 253. WHISTLEBLOWER PROTECTION.

(a) RETALIATION PROHIBITED.—No employer may discharge any employee or otherwise discriminate against any employee with respect to his compensation, terms,

conditions, or other privileges of employment because the employee (or any person acting pursuant to a request of the employee)—

(1) provided, caused to be provided, or is about to provide or cause to be provided to the employer, the Federal Government, or the attorney general of a State information relating to any violation of, or any act or omission the employee reasonably believes to be a violation of any provision of this Act or any order, rule, or regulation promulgated under this Act;

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

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

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

(b) ENFORCEMENT ACTION.—An employee covered by this section who alleges discrimination by an employer in violation of subsection (a) may bring an action governed by the rules, procedures, legal burdens of proof, and rem-

edies set forth in section 40(b) of the Consumer Product Safety Act (15 U.S.C. 2087(b)).

(c) EMPLOYER DEFINED.—As used in this section, the term ''employer'' means any person (including one or more individuals, partnerships, associations, corporations, trusts, professional membership organization including a certification, disciplinary, or other professional body, unincorporated organizations, nongovernmental organizations, or trustees) engaged in profit or nonprofit business or industry whose activities are governed by this Act, and any agent, contractor, subcontractor, grantee, or consultant of such person.

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

SEC. 254. CONSTRUCTION REGARDING COLLECTIVE BARGAINING.

Nothing in this division shall be construed to alter or supersede any statutory or other obligation to engage in collective bargaining over the terms or conditions of employment related to health care. Any plan amendment made pursuant to a collective bargaining agreement relating to the plan which amends the plan solely to conform to any requirement added by this division shall not be

treated as a termination of such collective bargaining agreement.

SEC. 255. SEVERABILITY.

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

SEC. 256. TREATMENT OF HAWAII PREPAID HEALTH CARE ACT.

(a) IN GENERAL.—Subject to this section—

(1) nothing in this division (or an amendment made by this division) shall be construed to modify or limit the application of the exemption for the Hawaii Prepaid Health Care Act (Haw. Rev. Stat. §§ 393–1 et seq.) as provided for under section 514(b)(5) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1144(b)(5)), and such exemption shall also apply with respect to the provisions of this division; and

(2) for purposes of this division (and the amendments made by this division), coverage provided pursuant to the Hawaii Prepaid Health Care Act shall be treated as a qualified health benefits plan providing acceptable coverage so long as the

Secretary of Labor determines that such coverage for employees (taking into account the benefits and the cost to employees for such benefits) is substantially equivalent to or greater than the coverage provided for employees pursuant to the essential benefits package.

(b) COORDINATION WITH STATE LAW OF HAWAII.—The Commissioner shall, based on ongoing consultation with the appropriate officials of the State of Hawaii, make adjustments to rules and regulations of the Commissioner under this division as may be necessary, as determined by the Commissioner, to most effectively coordinate the provisions of this division with the provisions of the Hawaii Prepaid Health Care Act, taking into account any changes made from time to time to the Hawaii Prepaid Health Care Act and related laws of such State.

SEC. 257. ACTIONS BY STATE ATTORNEYS GENERAL.

Any State attorney general may bring a civil action in the name of such State as *parens patriae* on behalf of natural persons residing in such State, in any district court of the United States or State court having jurisdiction of the defendant to secure monetary or equitable relief for violation of any provisions of this title or regulations issued thereunder. Nothing in this section shall be con-

strued as affecting the application of section 514 of the Employee Retirement Income Security Act of 1974.

SEC. 258. APPLICATION OF STATE AND FEDERAL LAWS REGARDING ABORTION.

(a) NO PREEMPTION OF STATE LAWS REGARDING ABORTION.—Nothing in this Act shall be construed to preempt or otherwise have any effect on State laws regarding the prohibition of (or requirement of) coverage, funding, or procedural requirements on abortions, including parental notification or consent for the performance of an abortion on a minor.

(b) NO EFFECT ON FEDERAL LAWS REGARDING ABORTION.—

(1) IN GENERAL.—Nothing in this Act shall be construed to have any effect on Federal laws regarding—

(A) conscience protection;

(B) willingness or refusal to provide abortion; and

(C) discrimination on the basis of the willingness or refusal to provide, pay for, cover, or refer for abortion or to provide or participate in training to provide abortion.

(c) NO EFFECT ON FEDERAL CIVIL RIGHTS LAW.—Nothing in this section shall alter the rights and obliga-

tions of employees and employers under title VII of the Civil Rights Act of 1964.

SEC. 259. NONDISCRIMINATION ON ABORTION AND RESPECT FOR RIGHTS OF CONSCIENCE.

(a) NONDISCRIMINATION.—A Federal agency or program, and any State or local government that receives Federal financial assistance under this Act (or an amendment made by this Act), may not—

(1) subject any individual or institutional health care entity to discrimination; or

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

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

(b) DEFINITION.—In this section, the term ''health care entity'' includes an individual physician or other health care professional, a hospital, a provider-sponsored organization, a health maintenance organization, a health insurance plan, or any other kind of health care facility, organization, or plan.

(c) ADMINISTRATION.—The Office for Civil Rights of the Department of Health and Human Services is designated to receive complaints of discrimination based on

this section, and coordinate the investigation of such complaints.

SEC. 260. AUTHORITY OF FEDERAL TRADE COMMISSION.

Section 6 of the Federal Trade Commission Act (15 U.S.C. 46) is amended by striking ''and prepare reports'' and all that follows and inserting the following: ''and prepare reports, and to share information under clauses (f) and (k), relating to the business of insurance. Notwithstanding section 4, such authority shall include the authority to conduct studies and prepare reports, and to share information under clauses (f) and (k), relating to the business of insurance, without regard to whether the entity or entities that is the subject of such studies, reports, or information is a for-profit or not-for-profit entity.''.

SEC. 261. CONSTRUCTION REGARDING STANDARD OF CARE.

(a) IN GENERAL.—The development, recognition, or implementation of any guideline or other standard under a provision described in subsection (b) shall not be construed to establish the standard of care or duty of care owed by health care providers to their patients in any medical malpractice action or claim (as defined in section 431(7) of the Health Care Quality Improvement Act of 1986 (42 U.S.C. 11151(7)).

(b) PROVISIONS DESCRIBED.—The provisions described in this subsection are the following:

(1) Section 324 (relating to modernized payment initiatives and delivery system reform under the public health option).

(2) The amendments made by section 1151 (relating to reducing potentially preventable hospital readmissions).

(3) The amendments made by section 1751 (relating to health care acquired conditions).

(4) Section 3131 of the Public Health Service Act (relating to the Task Force on Clinical Preventive Services), added by section 2301.

(5) Part D of title IX of the Public Health Service Act (relating to implementation of best practices in the delivery of health care), added by section 2401.

SEC. 262. RESTORING APPLICATION OF ANTITRUST LAWS TO HEALTH SECTOR INSURERS.

(a) AMENDMENT TO MCCARRAN-FERGUSON ACT.—Section 3 of the Act of March 9, 1945 (15 U.S.C. 1013), commonly known as the McCarran-Ferguson Act, is amended by adding at the end the following:

''(c)(1) Except as provided in paragraph (2), nothing contained in this Act shall modify, impair, or supersede

the operation of any of the antitrust laws with respect to price fixing, market allocation, or monopolization (or attempting to monopolize) by—

''(A) a person engaged in the business of health insurance, in connection with providing health insurance; or

''(B) a person engaged in the business of medical malpractice insurance, in connection with providing medical malpractice insurance.

''(2) Paragraph (1) shall not apply to—

''(A) collecting, compiling, classifying, or disseminating historical loss data;

''(B) determining a loss development factor applicable to historical loss data;

''(C) performing actuarial services if doing so does not involve a restraint of trade; or

''(D) information gathering and rate setting activities of a State insurance commission or other State regulatory entity with authority to set insurance rates.

''(3) For purposes of this subsection—

''(A) the term 'antitrust laws' has the meaning given it in subsection (a) of the first section of the Clayton Act, except that such term includes section 5 of the Federal Trade Commission Act to the ex-

tent that such section 5 applies to unfair methods of competition;

''(B) the term 'historical loss data' means information respecting claims paid, or reserves held for claims reported, by any person engaged in the business of insurance; and

''(C) the term 'loss development factor' means an adjustment to be made to the aggregate of losses incurred during a prior period of time that have been paid, or for which claims have been received and reserves are being held, in order to estimate the aggregate of the losses incurred during such period that will ultimately be paid.''.

(b) RELATED PROVISION.—For purposes of section 5 of the Federal Trade Commission Act (15 U.S.C. 45) to the extent such section applies to unfair methods of competition, section 3(c) of the McCarran-Ferguson Act shall apply with respect to the business of health insurance, and with respect to the business of medical malpractice insurance, without regard to whether such business is carried on for profit, notwithstanding the definition of ''Corporation'' contained in section 4 of the Federal Trade Commission Act.

(c) RELATED PRESERVATION OF ANTITRUST LAWS.—Except as provided in subsections (a) and (b),

nothing in this Act, or in the amendments made by this Act, shall be construed to modify, impair, or supersede the operation of any of the antitrust laws. For purposes of the preceding sentence, the term ''antitrust laws'' has the meaning given it in subsection (a) of the first section of the Clayton Act, except that it includes section 5 of the Federal Trade Commission Act to the extent that such section 5 applies to unfair methods of competition.

SEC. 263. STUDY AND REPORT ON METHODS TO INCREASE EHR USE BY SMALL HEALTH CARE PROVIDERS.

(a) STUDY.—The Secretary of Health and Human Services shall conduct a study of potential methods to increase the use of qualified electronic health records (as defined in section 3000(13) of the Public Health Service Act) by small health care providers. Such study shall consider at least the following methods:

(1) Providing for higher rates of reimbursement or other incentives for such health care providers to use electronic health records (taking into consideration initiatives by private health insurance companies and incentives provided under Medicare under title XVIII of the Social Security Act, Medicaid under title XIX of such Act, and other programs).

(2) Promoting low-cost electronic health record software packages that are available for use by such health care providers, including software packages that are available to health care providers through the Veterans Administration and other sources.

(3) Training and education of such health care providers on the use of electronic health records.

(4) Providing assistance to such health care providers on the implementation of electronic health records.

(b) REPORT.—Not later than December 31, 2013, the Secretary of Health and Human Services shall submit to Congress a report containing the results of the study conducted under subsection (a), including recommendations for legislation or administrative action to increase the use of electronic health records by small health care providers that include the use of both public and private funding sources.

TITLE III—HEALTH INSURANCE EXCHANGE AND RELATED PROVISIONS

Subtitle A—Health Insurance Exchange

SEC. 301. 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 243(b), the Commissioner shall—

(1) under section 304 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 303, and including with respect to oversight and enforcement;

(2) under section 305 facilitate outreach and enrollment in such plans of Exchange-eligible individuals and employers described in section 302; and

(3) conduct such activities related to the Health Insurance Exchange as required, including establishment of a risk pooling mechanism under section 306 and consumer protections under subtitle D of title II.

SEC. 302. EXCHANGE-ELIGIBLE INDIVIDUALS AND EMPLOYERS.

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

(b) DEFINITIONS.—In this division:

(1) EXCHANGE-ELIGIBLE INDIVIDUAL.—The term ''Exchange-eligible individual'' means an individual who is eligible under this section to be enrolled through the Health Insurance Exchange in an Exchange-participating health benefits plan and, with respect to family coverage, includes dependents of such individual.

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

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

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

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

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

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

(2) SECOND YEAR.—In Y2—

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

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

(3) THIRD AND SUBSEQUENT YEARS.—In Y3—

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

(B) small employers described in subsection (e)(3); and

(C) larger employers as permitted by the Commissioner under subsection (e)(4).

(d) INDIVIDUALS.—

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

(A) is not enrolled in coverage described in subparagraph (C) or (D) of paragraph (2); and

(B) is not enrolled in coverage as a full-time employee (or as a dependent of such an employee) under a group health plan if the coverage and an employer contribution under the plan meet the requirements of section 412.

For purposes of subparagraph (B), in the case of an individual who is self-employed, who has at least 1 employee, and who meets the requirements of section

412, such individual shall be deemed a full-time employee described in such subparagraph.

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

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

(B) GRANDFATHERED HEALTH INSURANCE COVERAGE; COVERAGE UNDER CURRENT GROUP HEALTH PLAN.—Coverage under a grandfathered health insurance coverage (as defined in subsection (a) of section 202) or under a current group health plan (described in subsection (b) of such section).

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

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

(E) MEMBERS OF THE ARMED FORCES AND DEPENDENTS (INCLUDING TRICARE).—Coverage under chapter 55 of title 10, United

States Code, including similar coverage furnished under section 1781 of title 38 of such Code.

(F) VA.—Coverage under the veteran's health care program under chapter 17 of title 38, United States Code.

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

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

(3) CONTINUING ELIGIBILITY PERMITTED.—

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

with an Exchange-participating health benefits plan.

(B) EXCEPTIONS.—

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

(I) under part A of the Medicare program;

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

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

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

(4) TRANSITION FOR CHIP ELIGIBLES.—An individual who is eligible for child health assistance under title XXI of the Social Security Act for a pe-

riod during Y1 shall not be an Exchange-eligible individual during such period.

(e) EMPLOYERS.—

(1) SMALLEST EMPLOYER.—Subject to paragraph (5), smallest employers described in this paragraph are employers with 25 or fewer employees.

(2) SMALLER EMPLOYERS.—Subject to paragraph (5), smaller employers described in this paragraph are employers that are not smallest employers described in paragraph (1) and have 50 or fewer employees.

(3) SMALL EMPLOYERS.—Subject to paragraph (5), small employers described in this paragraph are employers that are not described in paragraph (1) or (2) and have 100 or fewer employees.

(4) LARGER EMPLOYERS.—

(A) IN GENERAL.—Beginning with Y3, the Commissioner may permit employers not described in paragraph (1), (2), or (3) to be Exchange-eligible employers.

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

such other considerations as the Commissioner deems appropriate.

(5) CONTINUING ELIGIBILITY.—Once an employer is permitted to be an Exchange-eligible employer under this subsection and enrolls employees through the Health Insurance Exchange, the employer shall continue to be treated as an Exchange-eligible employer for each subsequent plan year regardless of the number of employees involved unless and until the employer meets the requirement of section 411(a) through paragraph (1) of such section by offering a group health plan and not through offering an Exchange-participating health benefits plan.

(6) 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 412 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 con-

sistent with the provisions of subtitle B of title IV.

(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.

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

(8) TREATMENT OF MULTI-EMPLOYER PLANS.—The plan sponsor of a group health plan (as defined in section 773(a) of the Employee Retirement Income Security Act of 1974) that is a multi-employer plan (as defined in section 3(37) of such Act) may obtain health insurance coverage with respect to participants in the plan through the Exchange to the same extent that an employer not described in paragraph (1) or (2) is permitted by the Commissioner to obtain health insurance coverage

through the Exchange as an Exchange-eligible employer.

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

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

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

(h) EXCHANGE ACCESS STUDY.—

(1) IN GENERAL.—The Commissioner shall conduct a study of access to the Health Insurance Exchange for individuals and for employers, including individuals and employers who are not eligible and

enrolled in Exchange-participating health benefits plans. The goal of the study is to determine if there are significant groups and types of individuals and employers who are not Exchange-eligible individuals or employers, but who would have improved benefits and affordability if made eligible for coverage in the Exchange.

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

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

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

(3) REPORT.—Not later than January 1 of Y3, in Y6, and thereafter, the Commissioner shall submit to Congress a report on the study conducted under this subsection and shall include in such report recommendations regarding changes in standards for Exchange eligibility for individuals and employers.

SEC. 303. BENEFITS PACKAGE LEVELS.

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

(b) LIMITATION ON HEALTH BENEFITS PLANS OFFERED BY OFFERING ENTITIES.—The Commissioner may not enter into a contract with a QHBP offering entity under section 304(c) for the offering of an Exchange-participating health benefits plan in a service area unless the following requirements are met:

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

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

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

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

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

(c) SPECIFICATION OF BENEFIT LEVELS FOR PLANS.—

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

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

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

(2) BASIC PLAN.—

(A) IN GENERAL.—A basic plan shall offer the essential benefits package required under title II for a qualified health benefits plan with an actuarial value of 70 percent of the full ac-

tuarial value of the benefits provided under the reference benefits package.

(B) TIERED COST-SHARING FOR AFFORDABLE CREDIT ELIGIBLE INDIVIDUALS.—In the case of an affordable credit eligible individual (as defined in section 342(a)(1)) enrolled in an Exchange-participating health benefits plan, the benefits under a basic plan are modified to provide for the reduced cost-sharing for the income tier applicable to the individual under section 324(c).

(3) ENHANCED PLAN.—An enhanced plan shall offer, in addition to the level of benefits under the basic plan, a lower level of cost-sharing as provided under title II consistent with section 223(b)(5)(A).

(4) PREMIUM PLAN.—A premium plan shall offer, in addition to the level of benefits under the basic plan, a lower level of cost-sharing as provided under title II consistent with section 223(b)(5)(B).

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

(6) RANGE OF PERMISSIBLE VARIATION IN COST-SHARING.—The Commissioner shall establish a permissible range of variation of cost-sharing for each basic, enhanced, and premium plan, except with respect to any benefit for which there is no cost-sharing permitted under the essential benefits package. Such variation shall permit a variation of not more than plus (or minus) 10 percent in cost-sharing with respect to each benefit category specified under section 222. Nothing in this subtitle shall be construed as prohibiting tiering in cost-sharing, including through preferred and participating providers and prescription drugs. In applying this paragraph, a health benefits plan may increase the cost-sharing by 10 percent within each category or tier, as applicable, and may decrease or eliminate cost-sharing in any category or tier as compared to the essential benefits package.

(d) TREATMENT OF STATE BENEFIT MANDATES.—Insofar as a State requires a health insurance issuer offering health insurance coverage to include benefits beyond the essential benefits package, such requirement shall continue to apply to an Exchange-participating health benefits plan, if the State has entered into an arrangement satisfactory to the Commissioner to reimburse the Com-

missioner for the amount of any net increase in affordability premium credits under subtitle C as a result of an increase in premium in basic plans as a result of application of such requirement.

(e) RULES REGARDING COVERAGE OF AND AFFORDABILITY CREDITS FOR SPECIFIED SERVICES.—

(1) ASSURED AVAILABILITY OF VARIED COVERAGE THROUGH THE HEALTH INSURANCE EXCHANGE.—The Commissioner shall assure that, of the Exchange participating health benefits plan offered in each premium rating area of the Health Insurance Exchange—

(A) there is at least one such plan that provides coverage of services described in subparagraphs (A) and (B) of section 222(d)(4); and

(B) there is at least one such plan that does not provide coverage of services described in section 222(d)(4)(A) which plan may also be one that does not provide coverage of services described in section 222(d)(4)(B).

(2) SEGREGATION OF FUNDS.—If a qualified health benefits plan provides coverage of services described in section 222(d)(4)(A), the plan shall pro-

vide assurances satisfactory to the Commissioner that—

(A) any affordability credits provided under subtitle C of title II are not used for purposes of paying for such services; and

(B) only premium amounts attributable to the actuarial value described in section 213(b) are used for such purpose.

SEC. 304. CONTRACTS FOR THE OFFERING OF EXCHANGE-PARTICIPATING HEALTH BENEFITS PLANS.

(a) CONTRACTING DUTIES.—In carrying out section 301(b)(1) and consistent with this subtitle:

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

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

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

(ii) Exchange-participating health benefits plans; and

(B) certify QHBP offering entities and qualified health benefits plans as meeting such

standards and requirements of this title and title II for purposes of this subtitle.

(2) SOLICITING AND NEGOTIATING BIDS; CONTRACTS.—

(A) BID SOLICITATION.—The Commissioner shall solicit bids from QHBP offering entities for the offering of Exchange-participating health benefits plans. Such bids shall include justification for proposed premiums.

(B) BID REVIEW AND NEGOTIATION.—The Commissioner shall, based upon a review of such bids including the premiums and their affordability, negotiate with such entities for the offering of such plans.

(C) DENIAL OF EXCESSIVE PREMIUMS.—The Commissioner shall deny excessive premiums and premium increases.

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

(3) FEDERAL ACQUISITION REGULATION.—In carrying out this subtitle, the Commissioner may

waive such provisions of the Federal Acquisition Regulation that the Commissioner determines to be inconsistent with the furtherance of this subtitle, other than provisions relating to confidentiality of information. Competitive procedures shall be used in awarding contracts under this subtitle to the extent that such procedures are consistent with this subtitle.

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

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

(2) DATA REPORTING.—The entity shall provide for the reporting of such information as the Commissioner may specify, including information necessary to administer the risk pooling mechanism described in section 306(b) and information to address disparities in health and health care.

(3) AFFORDABILITY.—The entity shall provide for affordable premiums.

(4) IMPLEMENTING AFFORDABILITY CREDITS.—The entity shall provide for implementation of the affordability credits provided for enrollees under subtitle C, including the reduction in cost-sharing under section 344(c).

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

(6) RISK POOLING PARTICIPATION.—The entity shall participate in such risk pooling mechanism as the Commissioner establishes under section 306(b).

(7) ESSENTIAL COMMUNITY PROVIDERS.—With respect to the basic plan offered by the entity, the entity shall include within the plan network those essential community providers, where available, that serve predominantly low-income, medically-underserved individuals, such as health care providers defined in section 340B(a)(4) of the Public Health Service Act and providers described in section 1927(c)(1)(D)(i)(IV) of the Social Security Act (as

amended by section 221 of Public Law 111–8). The Commissioner shall specify the extent to which and manner in which the previous sentence shall apply in the case of a basic plan with respect to which the Commissioner determines provides substantially all benefits through a health maintenance organization, as defined in section 2791(b)(3) of the Public Health Service Act. This paragraph shall not be construed to require a basic plan to contract with a provider if such provider refuses to accept the generally applicable payment rates of such plan.

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

(9) SPECIAL RULES WITH RESPECT TO INDIAN ENROLLEES AND INDIAN HEALTH CARE PROVIDERS.—

(A) CHOICE OF PROVIDERS.—The entity shall—

(i) demonstrate to the satisfaction of the Commissioner that it has contracted with a sufficient number of Indian health care providers to ensure timely access to covered services furnished by such pro-

viders to individual Indians through the entity's Exchange-participating health benefits plan; and

(ii) agree to pay Indian health care providers, whether such providers are participating or nonparticipating providers with respect to the entity, for covered services provided to those enrollees who are eligible to receive services from such providers at a rate that is not less than the level and amount of payment which the entity would make for the services of a participating provider which is not an Indian health care provider.

(B) SPECIAL RULE RELATING TO INDIAN HEALTH CARE PROVIDERS.—Provision of services by an Indian health care provider exclusively to Indians and their dependents shall not constitute discrimination under this Act.

(10) PROGRAM INTEGRITY STANDARDS.—The entity shall establish and operate a program to protect and promote the integrity of Exchange-participating health benefits plans it offers, in accordance with standards and functions established by the Commissioner.

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

(c) CONTRACTS.—

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

(2) TERM.—Each contract with a QHBP offering entity under this section shall be for a term of not less than one year, but may be made automatically renewable from term to term in the absence of notice of termination by either party.

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

(A) the Commissioner determines that such provider network does not meet such standards as the Commissioner shall establish under section 215; and

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

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

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

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

(B) ENFORCEMENT.—In carrying out authorities under this division relating to the Health Insurance Exchange, the Commissioner may impose one or more of the intermediate sanctions described in section 242(d).

(C) TERMINATION.—

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

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

(II) the Commissioner provides the entity with reasonable notice and

opportunity for hearing (including the right to appeal an initial decision) before terminating the contract.

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

(D) CONSTRUCTION.—Nothing in this subsection shall be construed as preventing the application of other sanctions under subtitle E of title II with respect to an entity for a violation of such a requirement.

(5) SPECIAL RULE RELATED TO COST-SHARING AND INDIAN HEALTH CARE PROVIDERS.—The contract under this section with a QHBP offering entity for a health benefits plan shall provide that if an individual who is an Indian is enrolled in such a plan and such individual receives a covered item or service from an Indian health care provider (regardless

of whether such provider is in the plan's provider network), the cost-sharing for such item or service shall be equal to the amount of cost-sharing that would be imposed if such item or service—

(A) had been furnished by another provider in the plan's provider network; or

(B) in the case that the plan has no such network, was furnished by a non-Indian provider.

(6) NATIONAL PLAN.—Nothing in this section shall be construed as preventing the Commissioner from entering into a contract under this subsection with a QHBP offering entity for the offering of a health benefits plan with the same benefits in every State so long as such entity is licensed to offer such plan in each State and the benefits meet the applicable requirements in each such State.

(d) NO DISCRIMINATION ON THE BASIS OF PROVISION OF ABORTION.—No Exchange participating health benefits plan may discriminate against any individual health care provider or health care facility because of its willingness or unwillingness to provide, pay for, provide coverage of, or refer for abortions.

SEC. 305. OUTREACH AND ENROLLMENT OF EXCHANGE-ELIGIBLE INDIVIDUALS AND EMPLOYERS IN EXCHANGE-PARTICIPATING HEALTH BENEFITS PLAN.

(a) IN GENERAL.—

(1) OUTREACH.—The Commissioner shall conduct outreach activities consistent with subsection (c), including through use of appropriate entities as described in paragraph (3) of such subsection, to inform and educate individuals and employers about the Health Insurance Exchange and Exchange-participating health benefits plan options. Such outreach shall include outreach specific to vulnerable populations, such as children, individuals with disabilities, individuals with mental illness, and individuals with other cognitive impairments.

(2) ELIGIBILITY.—The Commissioner shall make timely determinations of whether individuals and employers are Exchange-eligible individuals and employers (as defined in section 302).

(3) ENROLLMENT.—The Commissioner shall establish and carry out an enrollment process for Exchange-eligible individuals and employers, including at community locations, in accordance with subsection (b).

(b) ENROLLMENT PROCESS.—

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

(2) ENROLLMENT PERIODS.—

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

(B) SPECIAL ENROLLMENT.—The Commissioner shall also provide for special enrollment periods to take into account special circumstances of individuals and employers, such as an individual who—

(i) loses acceptable coverage;

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

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

(iv) experiences a significant change in income.

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

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

(A) IN GENERAL.—The Commissioner shall provide for a process under which individuals who are Exchange-eligible individuals described in subparagraph (B) are automatically enrolled under an appropriate Exchange-participating health benefits plan. Such process may involve a random assignment or some other

form of assignment that takes into account the health care providers used by the individual involved or such other relevant factors as the Commissioner may specify.

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

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

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

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

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

(ii) INDIVIDUALS ENROLLED IN A TERMINATED PLAN.—The individual who is enrolled in an Exchange-participating health benefits plan that is terminated (during or at the end of a plan year) and who does not otherwise enroll in another

Exchange-participating health benefits plan.

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

(c) COVERAGE INFORMATION AND ASSISTANCE.—

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

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

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

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

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

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

(D) ensure that the Internet Web site described in subparagraph (A) and the information described in subparagraph (B) is developed using plain language (as defined in section 233(a)(2)).

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

(d) COVERAGE FOR CERTAIN NEWBORNS UNDER MEDICAID.—

(1) IN GENERAL.—In the case of a child born in the United States who at the time of birth is not otherwise covered under acceptable coverage, for the period of time beginning on the date of birth and

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

(A) to be a Medicaid eligible individual for purposes of this division and Medicaid; and

(B) to be automatically enrolled in Medicaid as a traditional Medicaid eligible individual (as defined in section 1943(c) of the Social Security Act).

(2) EXTENDED TREATMENT AS MEDICAID ELIGIBLE INDIVIDUAL.—In the case of a child described in paragraph (1) who at the end of the period referred to in such paragraph is not otherwise covered under acceptable coverage, the child shall be deemed (until such time as the child obtains such coverage or the State otherwise makes a determination of the child's eligibility for medical assistance under its Medicaid plan pursuant to section 1943(b)(1) of the Social Security Act) to be a Medicaid eligible individual described in section 1902(l)(1)(B) of such Act.

(e) MEDICAID COVERAGE FOR MEDICAID ELIGIBLE INDIVIDUALS.—

(1) MEDICAID ENROLLMENT OBLIGATION.—An individual may apply, in the manner described in section 341(b)(1), for a determination of whether the individual is a Medicaid-eligible individual. If the individual is determined to be so eligible, the Commissioner, through the Medicaid memorandum of understanding under paragraph (2), shall provide for the enrollment of the individual under the State Medicaid plan in accordance with such memorandum of understanding. In the case of such an enrollment, the State shall provide for the same periodic redetermination of eligibility under Medicaid as would otherwise apply if the individual had directly applied for medical assistance to the State Medicaid agency.

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

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

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

(g) ROLE FOR ENROLLMENT AGENTS AND BROKERS.—Nothing in this division shall be construed to affect the role of enrollment agents and brokers under State law, including with regard to the enrollment of individuals and employers in qualified health benefits plans including the public health insurance option.

(h) ASSISTANCE FOR SMALL EMPLOYERS.—

(1) IN GENERAL.—The Commissioner, in consultation with the Small Business Administration, shall establish and carry out a program to provide to small employers counseling and technical assistance with respect to the provision of health insurance to employees of such employers through the Health Insurance Exchange.

(2) DUTIES.—The program established under paragraph (1) shall include the following services:

(A) Educational activities to increase awareness of the Health Insurance Exchange and available small employer health plan options.

(B) Distribution of information to small employers with respect to the enrollment and selection process for health plans available under the Health Insurance Exchange, including standardized comparative information on the health plans available under the Health Insurance Exchange.

(C) Distribution of information to small employers with respect to available affordability credits or other financial assistance.

(D) Referrals to appropriate entities of complaints and questions relating to the Health Insurance Exchange.

(E) Enrollment and plan selection assistance for employers with respect to the Health Insurance Exchange.

(F) Responses to questions relating to the Health Insurance Exchange and the program established under paragraph (1).

(3) AUTHORITY TO PROVIDE SERVICES DIRECTLY OR BY CONTRACT.—The Commissioner may provide services under paragraph (2) directly or by contract with nonprofit entities that the Commissioner determines capable of carrying out such services.

(4) SMALL EMPLOYER DEFINED.—In this subsection, the term ''small employer'' means an employer with less than 100 employees.

(i) PARTICIPATION OF SMALL EMPLOYER BENEFIT ARRANGEMENTS.—

(1) IN GENERAL.—The Commissioner may enter into contracts with small employer benefit arrangements to provide consumer information, outreach, and assistance in the enrollment of small employers (and their employees) who are members of such an arrangement under Exchange participating health benefits plans.

(2) SMALL EMPLOYER BENEFIT ARRANGEMENT DEFINED.—In this subsection, the term ''small employer benefit arrangement'' means a not-for-profit agricultural or other cooperative that—

(A) consists solely of its members and is operated for the primary purpose of providing affordable employee benefits to its members;

(B) only has as members small employers in the same industry or line of business;

(C) has no member that has more than a 5 percent voting interest in the cooperative; and

(D) is governed by a board of directors elected by its members.

SEC. 306. OTHER FUNCTIONS.

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

(b) COORDINATION OF RISK POOLING.—The Commissioner shall establish a mechanism whereby there is an adjustment made of the premium amounts payable among QHBP offering entities offering Exchange-participating health benefits plans of premiums collected for such plans that takes into account (in a manner specified by the Commissioner) the differences in the risk characteristics of individuals and employees enrolled under the different Exchange-participating health benefits plans offered by such entities so as to minimize the impact of adverse selection of enrollees among the plans offered by such entities. For purposes of the previous sentence, the Commissioner may utilize data regarding enrollee demographics, inpatient

and outpatient diagnoses (in a similar manner as such data are used under parts C and D of title XVIII of the Social Security Act), and such other information as the Secretary determines may be necessary, such as the actual medical costs of enrollees during the previous year.

SEC. 307. HEALTH INSURANCE EXCHANGE TRUST FUND.

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

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

(c) TRANSFERS TO TRUST FUND.—

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

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

(B) EMPLOYMENT TAXES ON EMPLOYERS NOT PROVIDING ACCEPTABLE COVERAGE.—The amounts received in the Treasury under sections 3111(c) and 3221(c) of the Internal Revenue Code of 1986 (relating to employers electing to not provide health benefits).

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

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

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

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

SEC. 308. OPTIONAL OPERATION OF STATE-BASED HEALTH INSURANCE EXCHANGES.

(a) IN GENERAL.—If—

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

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

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

(b) REQUIREMENTS FOR APPROVAL.—

(1) IN GENERAL.—The Commissioner may not approve a State-based Health Insurance Exchange

under this section unless the following requirements are met:

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

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

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

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

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

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

(v) enforcement activities consistent with Federal requirements.

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

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

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

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

(2) PRESUMPTION FOR CERTAIN STATE-OPERATED EXCHANGES.—

(A) IN GENERAL.—In the case of a State operating an Exchange prior to January 1, 2010, that seeks to operate the State-based Health Insurance Exchange under this section,

the Commissioner shall presume that such Exchange meets the standards under this section unless the Commissioner determines, after completion of the process established under subparagraph (B), that the Exchange does not comply with such standards.

(B) PROCESS.—The Commissioner shall establish a process to work with a State described in subparagraph (A) to provide assistance necessary to assure that the State's Exchange comes into compliance with the standards for approval under this section.

(c) CEASING OPERATION.—

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

(2) TERMINATION; HEALTH INSURANCE EXCHANGE RESUMPTION OF FUNCTIONS.—The Commissioner may terminate the approval (for some or all functions) of a State-based Health Insurance Ex-

change under this section if the Commissioner determines that such Exchange no longer meets the requirements of subsection (b) or is no longer capable of carrying out such functions in accordance with the requirements of this subtitle. In lieu of terminating such approval, the Commissioner may temporarily assume some or all functions of the State-based Health Insurance Exchange until such time as the Commissioner determines the State-based Health Insurance Exchange meets such requirements of subsection (b) and is capable of carrying out such functions in accordance with the requirements of this subtitle.

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

(d) RETENTION OF AUTHORITY.—

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

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

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

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

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

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

SEC. 309. INTERSTATE HEALTH INSURANCE COMPACTS.

(a) IN GENERAL.—Effective January 1, 2015, 2 or more States may form Health Care Choice Compacts (in this section referred to as ''compacts'') to facilitate the purchase of individual health insurance coverage across State lines.

(b) MODEL GUIDELINES.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall request the National Association of Insurance Commissioners (in this section referred to as ''NAIC'') to develop model guidelines for the creation of compacts. In developing such guidelines, the NAIC shall consult with consumers, health insurance issuers, the Secretary, and other interested parties. Such guidelines shall—

(1) provide for the sale of health insurance coverage to residents of all compacting States subject to the laws and regulations of a primary State designated by the health insurance issuer;

(2) require health insurance issuers issuing health insurance coverage in secondary States to maintain licensure in every such State;

(3) preserve the authority of the State of an individual's residence to address—

(A) market conduct;

(B) unfair trade practices;

(C) network adequacy;

(D) consumer protection standards;

(E) grievance and appeals;

(F) fair claims payment requirements; and

(G) prompt payment of claims;

(4) permit State insurance commissioners and other State agencies in secondary States access to the records of a health insurance issuer to the same extent as if the policy were written in that State; and

(5) provide for clear and conspicuous disclosure to consumers that the policy may not be subject to all the laws and regulations of the State in which the purchaser resides.

(c) REQUIRED CONSIDERATION.—If model guidelines developed under subsection (b) are submitted to the Secretary by January 1, 2013, the Secretary shall issue them as regulations. If the NAIC fails to submit such model guidelines by such date, the Secretary shall, no later than October 1, 2013, develop and promulgate the regulations implementing model guidelines described in subsection (b).

(d) NO REQUIREMENT TO COMPACT.—Nothing in this section shall be construed to require a State to join a compact.

(e) STATE AUTHORITY.—A State may not enter into a compact under this subsection unless the State enacts a law after the date of enactment of this Act that specifically authorizes the State to enter into such compact.

(f) CONSUMER PROTECTIONS.—If a State enters into a compact it must retain responsibility for the consumer

protections of its residents and its residents retain the right to bring a claim in a State court in the State in which the resident resides.

(g) ASSISTANCE TO COMPACTING STATES.—

(1) IN GENERAL.—Beginning January 1, 2015, the Secretary shall make awards, from amounts appropriated under paragraph (5), to States in the amount specified in paragraph (2) for the uses described in paragraph (3).

(2) AMOUNT SPECIFIED.—

(A) IN GENERAL.—For each fiscal year, the Secretary shall determine the total amount that the Secretary will make available for grants under this subsection.

(B) STATE AMOUNT.—For each State that is awarded a grant under paragraph (1), the amount of such grants shall be based on a formula established by the Secretary, not to exceed $1 million per State, under which States shall receive an award in the amount that is based on the following two components:

(i) A minimum amount for each State.

(ii) An additional amount based on population of the State.

(3) USE OF FUNDS.—A State shall use amounts awarded under this subsection for activities (including planning activities) related regulating health insurance coverage sold in secondary States.

(4) RENEWABILITY OF GRANT.—The Secretary may renew a grant award under paragraph (1) if the State receiving the grant continues to be a member of a compact.

(5) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as may be necessary to carry out this subsection in each of fiscal years 2015 through 2020.

SEC. 310. HEALTH INSURANCE COOPERATIVES.

(a) ESTABLISHMENT.—Not later than 6 months after the date of the enactment of this Act, the Commissioner, in consultation with the Secretary of the Treasury, shall establish a Consumer Operated and Oriented Plan program (in this section referred to as the ''CO–OP program'') under which the Commissioner may make grants and loans for the establishment and initial operation of not-for-profit, member–run health insurance cooperatives (in this section individually referred to as a ''cooperative'') that provide insurance through the Health Insurance Exchange or a State-based Health Insurance Exchange

under section 308. Nothing in this section shall be construed as requiring a State to establish such a cooperative.

(b) START-UP AND SOLVENCY GRANTS AND LOANS.—

(1) IN GENERAL.—Not later than 36 months after the date of the enactment of this Act, the Commissioner, acting through the CO–OP program, may make—

(A) loans (of such period and with such terms as the Secretary may specify) to cooperatives to assist such cooperatives with start-up costs; and

(B) grants to cooperatives to assist such cooperatives in meeting State solvency requirements in the States in which such cooperative offers or issues insurance coverage.

(2) CONDITIONS.—A grant or loan may not be awarded under this subsection with respect to a cooperative unless the following conditions are met:

(A) The cooperative is structured as a not-for-profit, member organization under the law of each State in which such cooperative offers, intends to offer, or issues insurance coverage, with the membership of the cooperative being

made up entirely of beneficiaries of the insurance coverage offered by such cooperative.

(B) The cooperative did not offer insurance on or before July 16, 2009, and the cooperative is not an affiliate or successor to an insurance company offering insurance on or before such date.

(C) The governing documents of the cooperative incorporate ethical and conflict of interest standards designed to protect against insurance industry involvement and interference in the governance of the cooperative.

(D) The cooperative is not sponsored by a State government.

(E) Substantially all of the activities of the cooperative consist of the issuance of qualified health benefits plans through the Health Insurance Exchange or a State-based health insurance exchange.

(F) The cooperative is licensed to offer insurance in each State in which it offers insurance.

(G) The governance of the cooperative must be subject to a majority vote of its members.

(H) As provided in guidance issued by the Secretary of Health and Human Services, the cooperative operates with a strong consumer focus, including timeliness, responsiveness, and accountability to members.

(I) Any profits made by the cooperative are used to lower premiums, improve benefits, or to otherwise improve the quality of health care delivered to members.

(3) PRIORITY.—The Commissioner, in making grants and loans under this subsection, shall give priority to cooperatives that—

(A) operate on a statewide basis;

(B) use an integrated delivery system; or

(C) have a significant level of financial support from nongovernmental sources.

(4) RULES OF CONSTRUCTION.—Nothing in this section shall be construed to prevent a cooperative established in one State from integrating with a cooperative established in another State the administration, issuance of coverage, or other activities related to acting as a QHBP offering entity. Nothing in this section shall be construed as preventing State governments from taking actions to permit such integration.

(5) AMORTIZATION OF GRANTS AND LOANS.—The Secretary shall provide for the repayment of grants or loans provided under this subsection to the Treasury in an amortized manner over a 10-year period.

(6) REPAYMENT FOR VIOLATIONS OF TERMS OF PROGRAM.—If a cooperative violates the terms of the CO–OP program and fails to correct the violation within a reasonable period of time, as determined by the Commissioner, the cooperative shall repay the total amount of any loan or grant received by such cooperative under this section, plus interest (at a rate determined by the Secretary).

(7) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated $5,000,000,000 for the period of fiscal years 2010 through 2014 to provide for grants and loans under this subsection.

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

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

(2) MEMBER.—The term ''member'', with respect to a cooperative, means an individual who, after the cooperative offers health insurance coverage, is enrolled in such coverage.

SEC. 311. RETENTION OF DOD AND VA AUTHORITY.

Nothing in this subtitle shall be construed as affecting any authority under title 38, United States Code, or chapter 55 of title 10, United States Code.

Subtitle B—Public Health Insurance Option

SEC. 321. ESTABLISHMENT AND ADMINISTRATION OF A PUBLIC HEALTH INSURANCE OPTION AS AN EXCHANGE-QUALIFIED HEALTH BENEFITS PLAN.

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

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

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

(2) ENSURING A LEVEL PLAYING FIELD.—Consistent with this subtitle, the public health insurance option shall comply with requirements that are applicable under this title to an Exchange-participating health benefits plan, including requirements related to benefits, benefit levels, provider networks, notices, consumer protections, and cost-sharing.

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

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

(B) may offer premium-plus plans.

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

(d) OMBUDSMAN.—The Secretary shall establish an office of the ombudsman for the public health insurance option which shall have duties with respect to the public health insurance option similar to the duties of the Medicare Beneficiary Ombudsman under section 1808(c)(2) of the Social Security Act.

(e) DATA COLLECTION.—The Secretary shall collect such data as may be required to establish premiums and payment rates for the public health insurance option and for other purposes under this subtitle, including to improve quality and to reduce racial, ethnic, and other disparities in health and health care. Nothing in this subtitle may be construed as authorizing the Secretary (or any employee or contractor) to create or maintain lists of non-medical personal property.

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

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

and individuals enrolled under such option under this title in the same manner as such provisions apply to Medicare and Medicare beneficiaries.

SEC. 322. PREMIUMS AND FINANCING.

(a) ESTABLISHMENT OF PREMIUMS.—

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

(A) in a manner that complies with the premium rules established by the Commissioner under section 213 for Exchange-participating health benefits plans; and

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

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

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

(2) CONTINGENCY MARGIN.—In establishing premium rates under paragraph (1), the Secretary shall include an appropriate amount for a contingency margin (which shall be not less than 90 days of estimated claims). Before setting such appropriate amount for years starting with Y3, the Secretary

shall solicit a recommendation on such amount from the American Academy of Actuaries.

(b) ACCOUNT.—

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

(2) START-UP FUNDING.—

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

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

(C) LIMITATION ON FUNDING.—Nothing in this section shall be construed as authorizing any additional appropriations to the Account, other than such amounts as are otherwise provided with respect to other Exchange-participating health benefits plans.

(3) NO BAILOUTS.—In no case shall the public health insurance option receive any Federal funds for purposes of insolvency in any manner similar to the manner in which entities receive Federal funding under the Troubled Assets Relief Program of the Secretary of the Treasury.

SEC. 323. PAYMENT RATES FOR ITEMS AND SERVICES.

(a) NEGOTIATION OF PAYMENT RATES.—

(1) IN GENERAL.—The Secretary shall negotiate payment for the public health insurance option for health care providers and items and services, including prescription drugs, consistent with this section and section 324.

(2) MANNER OF NEGOTIATION.—The Secretary shall negotiate such rates in a manner that results in payment rates that are not lower, in the aggregate, than rates under title XVIII of the Social Security Act, and not higher, in the aggregate, than the average rates paid by other QHBP offering entities for services and health care providers.

(3) INNOVATIVE PAYMENT METHODS.—Nothing in this subsection shall be construed as preventing the use of innovative payment methods such as those described in section 324 in connection with the negotiation of payment rates under this subsection.

(b) ESTABLISHMENT OF A PROVIDER NETWORK.—

(1) IN GENERAL.—Health care providers (including physicians and hospitals) participating in Medicare are participating providers in the public health insurance option unless they opt out in a process established by the Secretary consistent with this subsection.

(2) REQUIREMENTS FOR OPT-OUT PROCESS.—Under the process established under paragraph (1)—

(A) providers described in such paragraph shall be provided at least a 1-year period prior

to the first day of Y1 to opt out of participating in the public health insurance option;

(B) no provider shall be subject to a penalty for not participating in the public health insurance option;

(C) the Secretary shall include information on how providers participating in Medicare who chose to opt out of participating in the public health insurance option may opt back in; and

(D) there shall be an annual enrollment period in which providers may decide whether to participate in the public health insurance option.

(3) RULEMAKING.—Not later than 18 months before the first day of Y1, the Secretary shall promulgate rules (pursuant to notice and comment) for the process described in paragraph (1).

(c) LIMITATIONS ON REVIEW.—There shall be no administrative or judicial review of a payment rate or methodology established under this section or under section 324.

SEC. 324. MODERNIZED PAYMENT INITIATIVES AND DELIVERY SYSTEM REFORM.

(a) IN GENERAL.—For plan years beginning with Y1, the Secretary may utilize innovative payment mechanisms

and policies to determine payments for items and services under the public health insurance option. The payment mechanisms and policies under this section may include patient-centered medical home and other care management payments, accountable care organizations, value-based purchasing, bundling of services, differential payment rates, performance or utilization based payments, partial capitation, and direct contracting with providers.

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

(1) seeks to—

(A) improve health outcomes;

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

(C) provide efficient and affordable care;

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

(E) prevent or manage chronic illness; and

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

(c) ENCOURAGING THE USE OF HIGH VALUE SERVICES.—To the extent allowed by the benefit standards applied to all Exchange-participating health benefits plans,

the public health insurance option may modify cost-sharing and payment rates to encourage the use of services that promote health and value.

(d) PROMOTION OF DELIVERY SYSTEM REFORM.—The Secretary shall monitor and evaluate the progress of payment and delivery system reforms under this Act and shall seek to implement such reforms subject to the following:

(1) To the extent that the Secretary finds a payment and delivery system reform successful in improving quality and reducing costs, the Secretary shall implement such reform on as large a geographic scale as practical and economical.

(2) The Secretary may delay the implementation of such a reform in geographic areas in which such implementation would place the public health insurance option at a competitive disadvantage.

(3) The Secretary may prioritize implementation of such a reform in high cost geographic areas or otherwise in order to reduce total program costs or to promote high value care.

(e) NON-UNIFORMITY PERMITTED.—Nothing in this subtitle shall prevent the Secretary from varying payments based on different payment structure models (such as accountable care organizations and medical homes) under

the public health insurance option for different geographic areas.

SEC. 325. PROVIDER PARTICIPATION.

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

(b) LICENSURE OR CERTIFICATION.—

(1) IN GENERAL.—Except as provided in paragraph (2), the Secretary shall not allow a health care provider to participate in the public health insurance option unless such provider is appropriately licensed, certified, or otherwise permitted to practice under State law.

(2) SPECIAL RULE FOR IHS FACILITIES AND PROVIDERS.—The requirements under paragraph (1) shall not apply to—

(A) a facility that is operated by the Indian Health Service;

(B) a facility operated by an Indian Tribe or tribal organization under the Indian Self-Determination Act (Public Law 93–638);

(C) a health care professional employed by the Indian Health Service; or

(D) a health care professional—

(i) who is employed to provide health care services in a facility operated by an Indian Tribe or tribal organization under the Indian Self-Determination Act; and

(ii) who is licensed or certified in any State.

(c) PAYMENT TERMS FOR PROVIDERS.—

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

(A) PREFERRED PHYSICIANS.—Those physicians who agree to accept the payment under section 323 (without regard to cost-sharing) as the payment in full.

(B) PARTICIPATING, NON-PREFERRED PHYSICIANS.—Those physicians who agree not to impose charges (in relation to the payment described in section 323 for such physicians) that exceed the sum of the in-network cost-sharing plus 15 percent of the total payment for each item and service. The Secretary shall reduce the payment described in section 323 for such physicians.

(2) OTHER PROVIDERS.—The Secretary shall provide for the participation (on an annual or other basis specified by the Secretary) of health care providers (other than physicians) under the public health insurance option under which payment shall only be available if the provider agrees to accept the payment under section 323 (without regard to cost-sharing) as the payment in full.

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

SEC. 326. APPLICATION OF FRAUD AND ABUSE PROVISIONS.

Provisions of civil law 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 sections 3729 through 3733 of title 31, United States Code (commonly known as the False Claims Act), shall also apply to the public health insurance option.

SEC. 327. APPLICATION OF HIPAA INSURANCE REQUIREMENTS.

The requirements of sections 2701 through 2792 of the Public Health Service Act shall apply to the public health insurance option in the same manner as they apply to health insurance coverage offered by a health insurance issuer in the individual market.

SEC. 328. APPLICATION OF HEALTH INFORMATION PRIVACY, SECURITY, AND ELECTRONIC TRANSACTION REQUIREMENTS.

Part C of title XI of the Social Security Act, relating to standards for protections against the wrongful disclosure of individually identifiable health information, health information security, and the electronic exchange of health care information, shall apply to the public health insurance option in the same manner as such part applies to other health plans (as defined in section 1171(5) of such Act).

SEC. 329. ENROLLMENT IN PUBLIC HEALTH INSURANCE OPTION IS VOLUNTARY.

Nothing in this division shall be construed as requiring anyone to enroll in the public health insurance option. Enrollment in such option is voluntary.

SEC. 330. ENROLLMENT IN PUBLIC HEALTH INSURANCE OPTION BY MEMBERS OF CONGRESS.

Notwithstanding any other provision of this Act, Members of Congress may enroll in the public health insurance option.

SEC. 331. REIMBURSEMENT OF SECRETARY OF VETERANS AFFAIRS.

The Secretary of Health and Human Services shall seek to enter into a memorandum of understanding with the Secretary of Veterans Affairs regarding the recovery of costs related to non-service-connected care or services provided by the Secretary of Veterans Affairs to an individual covered under the public health insurance option in a manner consistent with recovery of costs related to non-service-connected care from private health insurance plans.

Subtitle C—Individual Affordability Credits

SEC. 341. AVAILABILITY THROUGH HEALTH INSURANCE EXCHANGE.

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

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

(A) an affordability premium credit under section 343 to be applied against the premium for the Exchange-participating health benefits plan in which the individual is enrolled; and

(B) an affordability cost-sharing credit under section 344 to be applied as a reduction of the cost-sharing otherwise applicable to such plan; and

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

(b) APPLICATION.—

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

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

(2) USE OF STATE MEDICAID AGENCIES.—If the Commissioner determines that a State Medicaid agency has the capacity to make a determination of eligibility for affordability credits under this subtitle and under the same standards as used by the Commissioner, under the Medicaid memorandum of understanding under section 305(e)(2)—

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

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

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

paragraph (1), there shall be a determination of whether the individual is a Medicaid-eligible individual. If the individual is determined to be so eligible, the Commissioner, through the Medicaid memorandum of understanding under section 305(e)(2), shall provide for the enrollment of the individual under the State Medicaid plan in accordance with such Medicaid memorandum of understanding. In the case of such an enrollment, the State shall provide for the same periodic redetermination of eligibility under Medicaid as would otherwise apply if the individual had directly applied for medical assistance to the State Medicaid agency.

(4) APPLICATION AND VERIFICATION OF REQUIREMENT OF CITIZENSHIP OR LAWFUL PRESENCE IN THE UNITED STATES.—

(A) REQUIREMENT.—No individual shall be an affordable credit eligible individual (as defined in section 342(a)(1)) unless the individual is a citizen or national of the United States or is lawfully present in a State in the United States (other than as a nonimmigrant described in a subparagraph (excluding subparagraphs (K), (T), (U), and (V)) of section

101(a)(15) of the Immigration and Nationality Act).

(B) DECLARATION OF CITIZENSHIP OR LAWFUL IMMIGRATION STATUS.—No individual shall be an affordable credit eligible individual unless there has been a declaration made, in a form and manner specified by the Health Choices Commissioner similar to the manner required under section 1137(d)(1) of the Social Security Act and under penalty of perjury, that the individual—

(i) is a citizen or national of the United States; or

(ii) is not such a citizen or national but is lawfully present in a State in the United States (other than as a non-immigrant described in a subparagraph (excluding subparagraphs (K), (T), (U), and (V)) of section 101(a)(15) of the Immigration and Nationality Act).

Such declaration shall be verified in accordance with subparagraph (C) or (D), as the case may be.

(C) VERIFICATION PROCESS FOR CITIZENS.—

(i) IN GENERAL.—In the case of an individual making the declaration described in subparagraph (B)(i), subject to clause (ii), section 1902(ee) of the Social Security Act shall apply to such declaration in the same manner as such section applies to a declaration described in paragraph (1) of such section.

(ii) SPECIAL RULES.—In applying section 1902(ee) of such Act under clause (i)—

(I) any reference in such section to a State is deemed a reference to the Commissioner (or other public entity making the eligibility determination);

(II) any reference to medical assistance or enrollment under a State plan is deemed a reference to provision of affordability credits under this subtitle;

(III) a reference to a newly enrolled individual under paragraph (2)(A) of such section is deemed a reference to an individual newly in re-

ceipt of an affordability credit under this subtitle;

(IV) approval by the Secretary shall not be required in applying paragraph (2)(B)(ii) of such section;

(V) paragraph (3) of such section shall not apply; and

(VI) before the end of Y2, the Health Choices Commissioner, in consultation with the Commissioner of Social Security, may extend the periods specified in paragraph (1)(B)(ii) of such section.

(D) VERIFICATION PROCESS FOR NONCITIZENS.—

(i) IN GENERAL.—In the case of an individual making the declaration described in subparagraph (B)(ii), subject to clause (ii), the verification procedures of paragraphs (2) through (5) of section 1137(d) of the Social Security Act shall apply to such declaration in the same manner as such procedures apply to a declaration described in paragraph (1) of such section.

(ii) SPECIAL RULES.—In applying such paragraphs of section 1137(d) of such Act under clause (i)—

(I) any reference in such paragraphs to a State is deemed a reference to the Health Choices Commissioner; and

(II) any reference to benefits under a program is deemed a reference to affordability credits under this subtitle.

(iii) APPLICATION TO STATE-BASED EXCHANGES.—In the case of the application of the verification process under this subparagraph to a State-based Health Insurance Exchange approved under section 308, section 1137(e) of such Act shall apply to the Health Choices Commissioner in relation to the State.

(E) ANNUAL REPORTS.—The Health Choices Commissioner shall report to Congress annually on the number of applicants for affordability credits under this subtitle, their citizenship or immigration status, and the disposition of their applications. Such report shall be

made publicly available and shall include information on—

(i) the number of applicants whose declaration of citizenship or immigration status, name, or social security account number was not consistent with records maintained by the Commissioner of Social Security or the Department of Homeland Security and, of such applicants, the number who contested the inconsistency and sought to document their citizenship or immigration status, name, or social security account number or to correct the information maintained in such records and, of those, the results of such contestations; and

(ii) the administrative costs of conducting the status verification under this paragraph.

(F) GAO REPORT.—Not later than the end of Y2, the Comptroller General of the United States shall submit to the Committee on Ways and Means, the Committee on Energy and Commerce, the Committee on Education and Labor, and the Committee on the Judiciary of

the House of Representatives and the Committee on Finance, the Committee on Health, Education, Labor, and Pensions, and the Committee on the Judiciary of the Senate a report examining the effectiveness of the citizenship and immigration verification systems applied under this paragraph. Such report shall include an analysis of the following:

(i) The causes of erroneous determinations under such systems.

(ii) The effectiveness of the processes used in remedying such erroneous determinations.

(iii) The impact of such systems on individuals, health care providers, and Federal and State agencies, including the effect of erroneous determinations under such systems.

(iv) The effectiveness of such systems in preventing ineligible individuals from receiving for affordability credits.

(v) The characteristics of applicants described in subparagraph (E)(i).

(G) PROHIBITION OF DATABASE.—Nothing in this paragraph or the amendments made by

paragraph (6) shall be construed as authorizing the Health Choices Commissioner or the Commissioner of Social Security to establish a database of information on citizenship or immigration status.

(H) INITIAL FUNDING.—

(i) IN GENERAL.—Out of any funds in the Treasury not otherwise appropriated, there is appropriated to the Commissioner of Social Security $30,000,000, to be available without fiscal year limit to carry out this paragraph and section 205(v) of the Social Security Act.

(ii) FUNDING LIMITATION.—In no case shall funds from the Social Security Administration's Limitation on Administrative Expenses be used to carry out activities related to this paragraph or section 205(v) of the Social Security Act.

(5) AGREEMENT WITH SOCIAL SECURITY COMMISSIONER.—

(A) IN GENERAL.—The Health Choices Commissioner shall enter into and maintain an agreement described in section 205(v)(2) of the

Social Security Act with the Commissioner of Social Security.

(B) FUNDING.—The agreement entered into under subparagraph (A) shall, for each fiscal year (beginning with fiscal year 2013)—

(i) provide funds to the Commissioner of Social Security for the full costs of the responsibilities of the Commissioner of Social Security under paragraph (4), including—

(I) acquiring, installing, and maintaining technological equipment and systems necessary for the fulfillment of the responsibilities of the Commissioner of Social Security under paragraph (4), but only that portion of such costs that are attributable to such responsibilities; and

(II) responding to individuals who contest with the Commissioner of Social Security a reported inconsistency with records maintained by the Commissioner of Social Security or the Department of Homeland Security relating to citizenship or immigration

status, name, or social security account number under paragraph (4);

(ii) based on an estimating methodology agreed to by the Commissioner of Social Security and the Health Choices Commissioner, provide such funds, within 10 calendar days of the beginning of the fiscal year for the first quarter and in advance for all subsequent quarters in that fiscal year; and

(iii) provide for an annual accounting and reconciliation of the actual costs incurred and the funds provided under the agreement.

(C) REVIEW OF ACCOUNTING.—The annual accounting and reconciliation conducted pursuant to subparagraph (B)(iii) shall be reviewed by the Inspectors General of the Social Security Administration and the Health Choices Administration, including an analysis of consistency with the requirements of paragraph (4).

(D) CONTINGENCY.—In any case in which agreement with respect to the provisions required under subparagraph (B) for any fiscal year has not been reached as of the first day

of such fiscal year, the latest agreement with respect to such provisions shall be deemed in effect on an interim basis for such fiscal year until such time as an agreement relating to such provisions is subsequently reached. In any case in which an interim agreement applies for any fiscal year under this subparagraph, the Commissioner of Social Security shall, not later than the first day of such fiscal year, notify the appropriate Committees of the Congress of the failure to reach the agreement with respect to such provisions for such fiscal year. Until such time as the agreement with respect to such provisions has been reached for such fiscal year, the Commissioner of Social Security shall, not later than the end of each 90-day period after October 1 of such fiscal year, notify such Committees of the status of negotiations between such Commissioner and the Health Choices Commissioner in order to reach such an agreement.

(E) APPLICATION TO PUBLIC ENTITIES ADMINISTERING AFFORDABILITY CREDITS.—If the Health Choices Commissioner provides for the conduct of verifications under paragraph

(4) through a public entity, the Health Choices Commissioner shall require the public entity to enter into an agreement with the Commissioner of Social Security which provides the same terms as the agreement described in this paragraph (and section 205(v) of the Social Security Act) between the Health Choices Commissioner and the Commissioner of Social Security, except that the Health Choices Commissioner shall be responsible for providing funds for the Commissioner of Social Security in accordance with subparagraphs (B) through (D).

(6) AMENDMENTS TO SOCIAL SECURITY ACT.—

(A) COORDINATION OF INFORMATION BETWEEN SOCIAL SECURITY ADMINISTRATION AND HEALTH CHOICES ADMINISTRATION.—

(i) IN GENERAL.—Section 205 of the Social Security Act (42 U.S.C. 405) is amended by adding at the end the following new subsection:

''Coordination of Information With Health Choices Administration

''(v)(1) The Health Choices Commissioner may collect and use the names and social security account numbers of individuals as required to provide for verification

of citizenship under subsection (b)(4)(C) of section 341 of the Affordable Health Care for America Act in connection with determinations of eligibility for affordability credits under such section.

''(2)(A) The Commissioner of Social Security shall enter into and maintain an agreement with the Health Choices Commissioner for the purpose of establishing, in compliance with the requirements of section 1902(ee) as applied pursuant to section 341(b)(4)(C) of the Affordable Health Care for America Act, a program for verifying information required to be collected by the Health Choices Commissioner under such section 341(b)(4)(C).

''(B) The agreement entered into pursuant to subparagraph (A) shall include such safeguards as are necessary to ensure the maintenance of confidentiality of any information disclosed for purposes of verifying information described in subparagraph (A) and to provide procedures for permitting the Health Choices Commissioner to use the information for purposes of maintaining the records of the Health Choices Administration.

''(C) The agreement entered into pursuant to subparagraph (A) shall provide that information provided by the Commissioner of Social Security to the Health Choices Commissioner pursuant to the agreement shall be provided

at such time, at such place, and in such manner as the Commissioner of Social Security determines appropriate.

''(D) Information provided by the Commissioner of Social Security to the Health Choices Commissioner pursuant to an agreement entered into pursuant to subparagraph (A) shall be considered as strictly confidential and shall be used only for the purposes described in this paragraph and for carrying out such agreement. Any officer or employee or former officer or employee of the Health Choices Commissioner, or any officer or employee or former officer or employee of a contractor of the Health Choices Commissioner, who, without the written authority of the Commissioner of Social Security, publishes or communicates any information in such individual's possession by reason of such employment or position as such an officer shall be guilty of a felony and, upon conviction thereof, shall be fined or imprisoned, or both, as described in section 208.

''(3) The agreement entered into under paragraph (2) shall provide for funding to the Commissioner of Social Security consistent with section 341(b)(5) of Affordable Health Care for America Act.

''(4) This subsection shall apply in the case of a public entity that conducts verifications under section 341(b)(4) of the Affordable Health Care for America Act

and the obligations of this subsection shall apply to such an entity in the same manner as such obligations apply to the Health Choices Commissioner when such Commissioner is conducting such verifications.''.

(ii) CONFORMING AMENDMENT.—Section 205(c)(2)(C) of such Act (42 U.S.C. 405(c)(2)(C)) is amended by adding at the end the following new clause:

''(x) For purposes of the administration of the verification procedures described in section 341(b)(4) of the Affordable Health Care for America Act, the Health Choices Commissioner may collect and use social security account numbers as provided for in section 205(v)(1).''.

(B) IMPROVING THE INTEGRITY OF DATA AND EFFECTIVENESS OF SAVE.—Section 1137(d) of the Social Security Act (42 U.S.C. 1320b–7(d)) is amended by adding at the end the following new paragraphs:

''(6)(A) With respect to the use by any agency of the system described in subsection (b) by programs specified in subsection (b) or any other use of such system, the U.S. Citizenship and Immigration Services and any other agency charged with the management of the system shall establish appropriate safeguards necessary to protect and

improve the integrity and accuracy of data relating to individuals by—

''(i) establishing a process though which such individuals are provided access to, and the ability to amend, correct, and update, their own personally identifiable information contained within the system;

''(ii) providing a written response, without undue delay, to any individual who has made such a request to amend, correct, or update such individual's own personally identifiable information contained within the system; and

''(iii) developing a written notice for user agencies to provide to individuals who are denied a benefit due to a determination of ineligibility based on a final verification determination under the system.

''(B) The notice described in subparagraph (A)(ii) shall include—

''(i) information about the reason for such notice;

''(ii) a description of the right of the recipient of the notice under subparagraph (A)(i) to contest such notice;

''(iii) a description of the right of the recipient under subparagraph (A)(i) to access and attempt to amend, correct, and update the recipient's own per-

sonally identifiable information contained within records of the system described in paragraph (3); and

''(iv) instructions on how to contest such notice and attempt to correct records of such system relating to the recipient, including contact information for relevant agencies.''.

(C) STREAMLINING ADMINISTRATION OF VERIFICATION PROCESS FOR UNITED STATES CITIZENS.—Section 1902(ee)(2) of the Social Security Act (42 U.S.C. 1396a(ee)(2)) is amended by adding at the end the following:

''(D) In carrying out the verification procedures under this subsection with respect to a State, if the Commissioner of Social Security determines that the records maintained by such Commissioner are not consistent with an individual's allegation of United States citizenship, pursuant to procedures which shall be established by the State in coordination with the Commissioner of Social Security, the Secretary of Homeland Security, and the Secretary of Health and Human Services—

''(i) the Commissioner of Social Security shall inform the State of the inconsistency;

''(ii) upon being so informed of the inconsistency, the State shall submit the information on the

individual to the Secretary of Homeland Security for a determination of whether the records of the Department of Homeland Security indicate that the individual is a citizen;

''(iii) upon making such determination, the Department of Homeland Security shall inform the State of such determination; and

''(iv) information provided by the Commissioner of Social Security shall be considered as strictly confidential and shall only be used by the State and the Secretary of Homeland Security for the purposes of such verification procedures.

''(E) Verification of status eligibility pursuant to the procedures established under this subsection shall be deemed a verification of status eligibility for purposes of this title, title XXI, and affordability credits under section 341(b)(4) of the Affordable Health Care for America Act, regardless of the program in which the individual is applying for benefits.''.

(c) USE OF AFFORDABILITY CREDITS.—

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

(2) FLEXIBILITY IN PLAN ENROLLMENT AUTHORIZED.—Beginning with Y3, the Commissioner

shall establish a process to allow an affordability premium credit under section 343, but not the affordability cost-sharing credit under section 344, to be used for enrollees in enhanced or premium plans. In the case of an affordable credit eligible individual who enrolls in an enhanced or premium plan, the individual shall be responsible for any difference between the premium for such plan and the affordability credit amount otherwise applicable if the individual had enrolled in a basic plan.

(3) PROHIBITION OF USE OF PUBLIC FUNDS FOR ABORTION COVERAGE.—An affordability credit may not be used for payment for services described in section 222(d)(4)(A).

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

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

SEC. 342. AFFORDABLE CREDIT ELIGIBLE INDIVIDUAL.

(a) DEFINITION.—

(1) IN GENERAL.—For purposes of this division, the term ''affordable credit eligible individual'' means, subject to subsection (b) and section 346, an individual who is lawfully present in a State in the United States (other than as a nonimmigrant described in a subparagraph (excluding subparagraphs (K), (T), (U), and (V)) of section 101(a)(15) of the Immigration and Nationality Act)—

(A) who is enrolled under an Exchange-participating health benefits plan and is not enrolled under such plan as an employee (or dependent of an employee) through an employer qualified health benefits plan that meets the requirements of section 412;

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

(C) who is not a Medicaid eligible individual, other than an individual during a transition period under section 302(d)(3)(B)(ii); and

(D) subject to paragraph (3), who is not enrolled in acceptable coverage (other than an Exchange-participating health benefits plan).

(2) TREATMENT OF FAMILY.—Except as the Commissioner may otherwise provide, members of

the same family who are affordable credit eligible individuals shall be treated as a single affordable credit individual eligible for the applicable credit for such a family under this subtitle.

(3) SPECIAL RULE FOR INDIANS.—Subparagraph (D) of paragraph (1) shall not apply to an individual who has coverage that is treated as acceptable coverage for purposes of section 59B(d)(2) of the Internal Revenue Code of 1986 but is not treated as acceptable coverage for purposes of this division.

(b) LIMITATIONS ON EMPLOYEE AND DEPENDENT DISQUALIFICATION.—

(1) IN GENERAL.—Subject to paragraph (2), the term ''affordable credit eligible individual'' does not include a full-time employee of an employer if the employer offers the employee coverage (for the employee and dependents) as a full-time employee under a group health plan if the coverage and employer contribution under the plan meet the requirements of section 412.

(2) EXCEPTIONS.—

(A) FOR CERTAIN FAMILY CIRCUMSTANCES.—The Commissioner shall establish such exceptions and special rules in the

case described in paragraph (1) as may be appropriate in the case of a divorced or separated individual or such a dependent of an employee who would otherwise be an affordable credit eligible individual.

(B) FOR UNAFFORDABLE EMPLOYER COVERAGE.—Beginning in Y2, in the case of full-time employees for which the cost of the employee premium for coverage under a group health plan would exceed 12 percent of current modified adjusted gross income (determined by the Commissioner on the basis of verifiable documentation), paragraph (1) shall not apply.

(c) INCOME DEFINED.—

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

(2) STUDY OF INCOME DISREGARDS.—The Commissioner shall conduct a study that examines the application of income disregards for purposes of this subtitle. Not later than the first day of Y2, the Commissioner shall submit to Congress a report on such study and shall include such recommendations as the Commissioner determines appropriate.

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

SEC. 343. AFFORDABILITY PREMIUM CREDIT.

(a) IN GENERAL.—The affordability premium credit under this section for an affordable credit eligible individual enrolled in an Exchange-participating health benefits plan is in an amount equal to the amount (if any) by which the reference premium amount specified in subsection (c), exceeds the affordable premium amount specified in subsection (b) for the individual, except that in no case shall the affordable premium credit exceed the premium for the plan.

(b) AFFORDABLE PREMIUM AMOUNT.—

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

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

(B) the individual's modified adjusted gross income for such plan year.

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

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

(d) TABLE OF PREMIUM PERCENTAGE LIMITS, ACTUARIAL VALUE PERCENTAGES, AND OUT-OF-POCKET LIMITS FOR Y1 BASED ON INCOME TIER.—

(1) IN GENERAL.—For purposes of this subtitle, subject to paragraph (3) and section 346, the table specified in this subsection is as follows:

In the case of modified adjusted gross income (expressed as a percent of FPL) within the following income tier:	The initial premium percentage is—	The final premium percentage is—	The actuarial value percentage is—	The out-of-pocket limit for Y1 is—
133% through 150%	1.5%	3.0%	97%	$500
150% through 200%	3.0%	5.5%	93%	$1,000
200% through 250%	5.5%	8.0%	85%	$2,000
250% through 300%	8.0%	10.0%	78%	$4,000
300% through 350%	10.0%	11.0%	72%	$4,500
350% through 400%	11.0%	12.0%	70%	$5,000

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

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

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

(3) INDEXING.—For years after Y1, the Commissioner shall adjust the initial and final premium percentages to maintain the ratio of governmental to

enrollee shares of premiums over time, for each income tier identified in the table in paragraph (1).

SEC. 344. AFFORDABILITY COST-SHARING CREDIT.

(a) IN GENERAL.—The affordability cost-sharing credit under this section for an affordable credit eligible individual enrolled in an Exchange-participating health benefits plan is in the form of the cost-sharing reduction described in subsection (b) provided under this section for the income tier in which the individual is classified based on the individual's modified adjusted gross income.

(b) COST-SHARING REDUCTIONS.—The Commissioner shall specify a reduction in cost-sharing amounts and the annual limitation on cost-sharing specified in section 222(c)(2)(B) under a basic plan for each income tier specified in the table under section 343(d), with respect to a year, in a manner so that, as estimated by the Commissioner—

(1) the actuarial value of the coverage with such reduced cost-sharing amounts (and the reduced annual cost-sharing limit) is equal to the actuarial value percentage (specified in the table under section 343(d) for the income tier involved) of the full actuarial value if there were no cost-sharing imposed under the plan; and

(2) the annual limitation on cost-sharing specified in section 222(c)(2)(B) is reduced to a level that does not exceed the maximum out-of-pocket limit specified in subsection (c).

(c) MAXIMUM OUT-OF-POCKET LIMIT.—

(1) IN GENERAL.—Subject to paragraph (2), the maximum out-of-pocket limit specified in this subsection for an individual within an income tier—

(A) for individual coverage—

(i) for Y1 is the out-of-pocket limit for Y1 specified in subsection (c) in the table under section 343(d) for the income tier involved; or

(ii) for a subsequent year is such out-of-pocket limit for the previous year under this subparagraph increased (rounded to the nearest $10) for each subsequent year by the percentage increase in the enrollment-weighted average of premium increases for basic plans applicable to such year; or

(B) for family coverage is twice the maximum out-of-pocket limit under subparagraph (A) for the year involved.

(2) ADJUSTMENT.—The Commissioner shall adjust the maximum out-of-pocket limits under paragraph (1) to ensure that such limits meet the actuarial value percentage specified in the table under section 343(d) for the income tier involved.

(d) DETERMINATION AND PAYMENT OF COST-SHARING AFFORDABILITY CREDIT.—In the case of an affordable credit eligible individual in a tier enrolled in an Exchange-participating health benefits plan offered by a QHBP offering entity, the Commissioner shall provide for payment to the offering entity of an amount equivalent to the increased actuarial value of the benefits under the plan provided under section 303(c)(2)(B) resulting from the reduction in cost-sharing described in subsections (b) and (c).

SEC. 345. INCOME DETERMINATIONS.

(a) IN GENERAL.—In applying this subtitle for an affordability credit for an individual for a plan year, the individual's income shall be the income (as defined in section 342(c)) for the individual for the most recent taxable year (as determined in accordance with rules of the Commissioner). The Federal poverty level applied shall be such level in effect as of the date of the application.

(b) PROGRAM INTEGRITY; INCOME VERIFICATION PROCEDURES.—

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

(2) INCOME VERIFICATION.—

(A) IN GENERAL.—Upon an initial application of an individual for an affordability credit under this subtitle (or in applying section 342(b)) or upon an application for a change in the affordability credit based upon a significant change in modified adjusted gross income described in subsection (c)(1)—

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

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

(B) ALTERNATIVE PROCEDURES.—The Commissioner shall establish procedures for the verification of income for purposes of this sub-

title if no income tax return is available for the most recent completed tax year.

(c) SPECIAL RULES.—

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

(2) REPORTING OF SIGNIFICANT CHANGES IN INCOME.—The Commissioner shall establish rules under which an individual determined to be an affordable credit eligible individual would be required to inform the Commissioner when there is a significant change in the modified adjusted gross income of the individual (expressed as a percentage of the FPL for a family of the size involved) and of the in-

formation regarding such change. Such mechanism shall provide for guidelines that specify the circumstances that qualify as a significant change, the verifiable information required to document such a change, and the process for submission of such information. If the Commissioner receives new information from an individual regarding the modified adjusted gross income of the individual, the Commissioner shall provide for a redetermination of the individual's eligibility to be an affordable credit eligible individual.

(3) TRANSITION FOR CHIP.—In the case of a child described in section 302(d)(2), the Commissioner shall establish rules under which the modified adjusted gross income of the child is deemed to be no greater than the family income of the child as most recently determined before Y1 by the State under title XXI of the Social Security Act.

(4) STUDY OF GEOGRAPHIC VARIATION IN APPLICATION OF FPL.—

(A) IN GENERAL.—The Secretary of Health and Human Services shall conduct a study to examine the feasibility and implication of adjusting the application of the Federal poverty level under this subtitle for different geo-

graphic areas so as to reflect the variations in cost-of-living among different areas within the United States. If the Secretary determines that an adjustment is feasible, the study should include a methodology to make such an adjustment. Not later than the first day of Y1, the Secretary shall submit to Congress a report on such study and shall include such recommendations as the Secretary determines appropriate.

(B) INCLUSION OF TERRITORIES.—

(i) IN GENERAL.—The Secretary shall ensure that the study under subparagraph (A) covers the territories of the United States and that special attention is paid to the disparity that exists among poverty levels and the cost of living in such territories and to the impact of such disparity on efforts to expand health coverage and ensure health care.

(ii) TERRITORIES DEFINED.—In this subparagraph, the term ''territories of the United States'' includes the Commonwealth of Puerto Rico, the United States Virgin Islands, Guam, the Northern Mar-

iana Islands, and any other territory or possession of the United States.

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

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

(2) in the case of such an intentional misrepresentation or other egregious circumstances specified by the Commissioner, the Commissioner may impose an additional penalty.

SEC. 346. SPECIAL RULES FOR APPLICATION TO TERRITORIES.

(a) ONE-TIME ELECTION FOR TREATMENT AND APPLICATION OF FUNDING.—

(1) IN GENERAL.—A territory may elect, in a form and manner specified by the Commissioner in consultation with the Secretary of Health and

Human Services and the Secretary of the Treasury and not later than October 1, 2012, either—

(A) to be treated as a State for purposes of applying this title and title II; or

(B) not to be so treated but instead, to have the dollar limitation otherwise applicable to the territory under subsections (f) and (g) of section 1108 of the Social Security Act (42 U.S.C. 1308) for a fiscal year increased by a dollar amount equivalent to the cap amount determined under subsection (c)(2) for the territory as applied by the Secretary for the fiscal year involved.

(2) CONDITIONS FOR ACCEPTANCE.—The Commissioner has the nonreviewable authority to accept or reject an election described in paragraph (1)(A). Any such acceptance is—

(A) contingent upon entering into an agreement described in subsection (b) between the Commissioner and the territory and subsection (c); and

(B) subject to the approval of the Secretary of Health and Human Services and the Secretary of the Treasury and subject to such other terms and conditions as the Commis-

sioner, in consultation with such Secretaries, may specify.

(3) DEFAULT RULE.—A territory failing to make such an election (or having an election under paragraph (1)(A) not accepted under paragraph (2)) shall be treated as having made the election described in paragraph (1)(B).

(b) AGREEMENT FOR SUBSTITUTION OF PERCENTAGES FOR AFFORDABILITY CREDITS.—

(1) NEGOTIATION.—In the case of a territory making an election under subsection (a)(1)(A) (in this section referred to as an ''electing territory'') , the Commissioner, in consultation with the Secretaries of Health and Human Services and the Treasury, shall enter into negotiations with the government of such territory so that, before Y1, there is an agreement reached between the parties on the percentages that shall be applied under paragraph (2) for that territory. The Commissioner shall not enter into such an agreement unless—

(A) payments made under this subtitle with respect to residents of the territory are consistent with the cap established under subsection (c) for such territory and with subsection (d); and

(B) the requirements of paragraphs (3) and (4) are met.

(2) APPLICATION OF SUBSTITUTE PERCENTAGES AND DOLLAR AMOUNTS.—In the case of an electing territory, there shall be substituted in section 342(a)(1)(B) and in the table in section 341(d)(1) for 400 percent, 133 percent, and other percentages and dollar amounts specified in such table, such respective percentages and dollar amounts as are established under the agreement under paragraph (1) consistent with the following:

(A) NO INCOME GAP BETWEEN MEDICAID AND AFFORDABILITY CREDITS.—The substituted percentages shall be specified in a manner so as to prevent any gap in coverage for individuals between income level at which medical assistance is available through Medicaid and the income level at which affordability credits are available.

(B) ADJUSTMENT FOR OUT-OF-POCKET RESPONSIBILITY FOR PREMIUMS AND COST-SHARING IN RELATION TO INCOME.—The substituted percentages of FPL for income tiers under such table shall be specified in a manner so that—

(i) affordable credit eligible individuals residing in the territory bear the same out-of-pocket responsibility for premiums and cost-sharing in relation to average income for residents in that territory, as

(ii) the out-of-pocket responsibility for premiums and cost-sharing for affordable credit eligible individuals residing in the 50 States or the District of Columbia in relation to average income for such residents.

(3) SPECIAL RULES WITH RESPECT TO APPLICATION OF TAX AND PENALTY PROVISIONS.—The electing territory shall enact one or more laws under which provisions similar to the following provisions apply with respect to such territory:

(A) Section 59B of the Internal Revenue Code of 1986, except that any resident of the territory who is not an affordable credit eligible individual but who would be an affordable credit eligible individual if such resident were a resident of one of the 50 States (and any qualifying child residing with such individual) may be treated as covered by acceptable coverage.

(B) Section 4980H of the Internal Revenue Code of 1986 and section 502(c)(11) of

the Employee Retirement Income Security Act of 1974.

(C) Section 3121(c) of the Internal Revenue Code of 1986.

(4) IMPLEMENTATION OF INSURANCE REFORM AND CONSUMER PROTECTION REQUIREMENTS.—The electing territory shall enact and implement such laws and regulations as may be required to apply the requirements of title II with respect to health insurance coverage offered in the territory.

(c) CAP ON ADDITIONAL EXPENDITURES.—

(1) IN GENERAL.—In entering into an agreement with an electing territory under subsection (b), the Commissioner shall ensure that the aggregate expenditures under this subtitle with respect to residents of such territory during the period beginning with Y1 and ending with 2019 will not exceed the cap amount specified in paragraph (2) for such territory. The Commissioner shall adjust from time to time the percentages applicable under such agreement as needed in order to carry out the previous sentence.

(2) CAP AMOUNT.—

(A) IN GENERAL.—The cap amount specified in this paragraph—

(i) for Puerto Rico is $3,700,000,000 increased by the amount (if any) elected under subparagraph (C); or

(ii) for another territory is the portion of $300,000,000 negotiated for such territory under subparagraph (B).

(B) NEGOTIATION FOR CERTAIN TERRITORIES.—The Commissioner in consultation with the Secretary of Health and Human Services shall negotiate with the governments of the territories (other than Puerto Rico) to allocate the amount specified in subparagraph (A)(ii) among such territories.

(C) OPTIONAL SUPPLEMENTATION FOR PUERTO RICO.—

(i) IN GENERAL.—Puerto Rico may elect, in a form and manner specified by the Secretary of Health and Human Services in consultation with the Commissioner to increase the dollar amount specified in subparagraph (A)(i) by up to $1,000,000,000.

(ii) OFFSET IN MEDICAID CAP.—If Puerto Rico makes the election described in clause (i), the Secretary shall decrease

the dollar limitation otherwise applicable to Puerto Rico under subsections (f) and (g) of section 1108 of the Social Security Act (42 U.S.C. 1308) for a fiscal year by the additional aggregate payments the Secretary estimates will be payable under this section for the fiscal year because of such election.

(d) LIMITATION ON FUNDING.—In no case shall this section (including the agreement under subsection (b)) permit—

(1) the obligation of funds for expenditures under this subtitle for periods beginning on or after January 1, 2020; or

(2) any increase in the dollar limitation described in subsection (a)(1)(B) for any portion of any fiscal year occurring on or after such date.

SEC. 347. 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 IV—SHARED RESPONSIBILITY

Subtitle A—Individual Responsibility

SEC. 401. 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 501 of this Act).

Subtitle B—Employer Responsibility

PART 1—HEALTH COVERAGE PARTICIPATION REQUIREMENTS

SEC. 411. HEALTH COVERAGE PARTICIPATION REQUIREMENTS.

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

(1) OFFER OF COVERAGE.—The employer offers each employee individual and family coverage under a qualified health benefits plan (or under a current employment-based health plan (within the meaning of section 202(b))) in accordance with section 412.

(2) CONTRIBUTION TOWARDS COVERAGE.—If an employee accepts such offer of coverage, the em-

ployer makes timely contributions towards such coverage in accordance with section 412.

(3) CONTRIBUTION IN LIEU OF COVERAGE.—Beginning with Y2, if an employee declines such offer but otherwise obtains coverage in an Exchange-participating health benefits plan (other than by reason of being covered by family coverage as a spouse or dependent of the primary insured), the employer shall make a timely contribution to the Health Insurance Exchange with respect to each such employee in accordance with section 413.

SEC. 412. EMPLOYER RESPONSIBILITY TO CONTRIBUTE TOWARD EMPLOYEE AND DEPENDENT COVERAGE.

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

(1) OFFERING OF COVERAGE.—The employer offers the coverage described in section 411(1). In the case of an Exchange-eligible employer, the employer may offer such coverage either through an Exchange-participating health benefits plan or other than through such a plan.

(2) EMPLOYER REQUIRED CONTRIBUTION.—The employer timely pays to the issuer of such cov-

erage an amount not less than the employer required contribution specified in subsection (b) for such coverage.

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

(A) The name, date, and employer identification number of the employer.

(B) A certification as to whether the employer offers to its full-time employees (and their dependents) the opportunity to enroll in a qualified health benefits plan or a current employment-based health plan (within the meaning of section 202(b)).

(C) If the employer certifies that the employer did offer to its full-time employees (and their dependents) the opportunity to so enroll—

(i) the months during the calendar year for which such coverage was available; and

(ii) the monthly premium for the lowest cost option in each of the enrollment categories under each such plan offered to employees.

(D) The name, address, and TIN of each full-time employee during the calendar year and the months (if any) during which such employee (and any dependents) were covered under any such plans.

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

This subsection shall supersede any law of a State which would prevent automatic payroll deduction of employee contributions to an employment-based health plan.

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

(1) FULL-TIME EMPLOYEES.—The minimum employer contribution described in this subsection for coverage of a full-time employee (and, if any, the employee's spouse and qualifying children (as defined in section 152(c) of the Internal Revenue Code of 1986)) under a qualified health benefits plan (or current employment-based health plan) is equal to—

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

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

(2) APPLICABLE PREMIUM FOR EXCHANGE COVERAGE.—In this subtitle, the amount of the applicable premium of the lowest cost plan with respect to coverage of an employee under an Exchange-participating health benefits plan is the reference premium amount under section 343(c) for individual coverage (or, if elected, family coverage) for the premium rating area in which the individual or family resides.

(3) MINIMUM EMPLOYER CONTRIBUTION FOR EMPLOYEES OTHER THAN FULL-TIME EMPLOYEES.—In the case of coverage for an employee who is not a full-time employee, the amount of the minimum 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 such employee into the employment-based health benefits plan for individual coverage under the plan option with the lowest applicable employee premium.

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

(3) NOTICE REQUIREMENTS.—

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

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

SEC. 413. EMPLOYER CONTRIBUTIONS IN LIEU OF COVERAGE.

(a) IN GENERAL.—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) but not to exceed the minimum employer contribution described in section 412(b)(1)(A). Any such contribution—

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

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

(b) SPECIAL RULES FOR SMALL EMPLOYERS.—

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

If the annual payroll of such employer for the preceding calendar year:	The applicable percentage is:
Does not exceed $500,000	0 percent
Exceeds $500,000, but does not exceed $585,000	2 percent
Exceeds $585,000, but does not exceed $670,000	4 percent
Exceeds $670,000, but does not exceed $750,000	6 percent

(2) SMALL EMPLOYER.—For purposes of this subsection, the term ''small employer'' means any employer for any calendar year if the annual payroll of such employer for the preceding calendar year does not exceed $750,000.

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

aggregate wages paid by the employer during such calendar year.

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

SEC. 414. AUTHORITY RELATED TO IMPROPER STEERING.

The Health Choices Commissioner (in coordination with the Secretary of Labor, the Secretary of Health and Human Services, and the Secretary of the Treasury) shall have authority to set standards for determining whether employers or insurers are undertaking any actions to affect the risk pool within the Health Insurance Exchange by inducing individuals to decline coverage under a qualified health benefits plan (or current employment-based health plan (within the meaning of section 202(b)) offered by the employer and instead to enroll in an Exchange-participating health benefits plan. An employer violating such standards shall be treated as not meeting the requirements of this section.

SEC. 415. IMPACT STUDY ON EMPLOYER RESPONSIBILITY REQUIREMENTS.

(a) IN GENERAL.—The Secretary of Labor shall conduct a study to examine the effect of the exemptions under section 512(a) and coverage thresholds under this division (in this section referred to collectively as ″employer re-

sponsibility requirements)on employment-based health plan sponsorship, generally and within specific industries, and the effect of such requirements and thresholds on employers, employment-based health plans, and employees in each industry.

(b) ANNUAL REPORT.—The Secretary of Labor annually shall submit to Congress a report on findings on how employer responsibility requirements have impacted and are likely to impact employers, plans, and employees during the previous year and projected trends.

(c) LEGISLATIVE RECOMMENDATIONS.—No later than January 1, 2012 and on an annual basis thereafter, the Secretary of Labor shall submit legislative recommendations to Congress to modify the employer responsibility requirements if the Secretary determines that the requirements are detrimentally affecting or will detrimentally affect employer plan sponsorship or otherwise creating inequities among employers, health plans, and employees. The Secretary may also submit such recommendations as the Secretary determines necessary to improve and strengthen employment-based health plan sponsorship, employer responsibility, and related proposals that would enhance the delivery of health care benefits between employers and employees.

SEC. 416. STUDY ON EMPLOYER HARDSHIP EXEMPTION.

(a) IN GENERAL.—The Secretary of Labor together with the Secretary of Treasury, the Secretary of Health and Human Services, and the Commissioner, shall conduct a study to examine the impact of the employer responsibility requirements described in section 415(a) and make a recommendation to Congress about whether an employer hardship exemption would be appropriate.

(b) ITEMS INCLUDED IN STUDY.—Within such study the Secretaries and Commissioner shall examine cases where such employer responsibility requirements may pose a particular hardship, and specifically look at employers by industry, profit margin, length of time in business, and size. In this examination, the economic conditions shall be considered, including the rate of increase in business costs, the availability of short-term credit lines, and abilities to restructure debt. In addition, the study shall examine the impact an employer hardship waiver could have on employees.

(c) REPORT.—Not later than January 1, 2012, the Secretaries and Commissioner shall report to Congress on their findings and make a recommendation regarding the need or lack of need for a partial or complete employer hardship waiver. The Secretaries and Commissioner may also submit recommendations about the criteria Congress should include when developing eligibility requirements for

the employer hardship waiver and what safeguards are necessary to protect the employees of that employer.

PART 2—SATISFACTION OF HEALTH COVERAGE PARTICIPATION REQUIREMENTS

SEC. 421. SATISFACTION OF HEALTH COVERAGE PARTICIPATION REQUIREMENTS UNDER THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974.

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

"PART 8—NATIONAL HEALTH COVERAGE PARTICIPATION REQUIREMENTS

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

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

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

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

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

''(1) such election shall be treated as the establishment and maintenance of a group health plan (as defined in section 733(a)) for purposes of this title, subject to section 251 of the ; and

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

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

''(c) RECORDKEEPING.—To facilitate the audits described in subsection (b), the Secretary shall promulgate recordkeeping requirements for employers to account for

both employees of the employer and individuals whom the employer has not treated as employees of the employer but with whom the employer, in the course of its trade or business, has engaged for the performance of labor or services. The scope and content of such recordkeeping requirements shall be determined by the Secretary and shall be designed to ensure that employees who are not properly treated as such may be identified and properly treated.

"SEC. 803. HEALTH COVERAGE PARTICIPATION REQUIREMENTS.

''For purposes of this part, the term 'health coverage participation requirements' means the requirements of part 1 of subtitle B of title IV of division A of (as in effect on the date of the enactment of such Act).

"SEC. 804. RULES FOR APPLYING REQUIREMENTS.

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

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

''(1) separate lines of business, and

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

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

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

"SEC. 806. REGULATIONS.

''The Secretary may promulgate such regulations as may be necessary or appropriate to carry out the provisions of this part, in accordance with section 424(a) of the . The Secretary may promulgate any interim final rules as the Secretary determines are appropriate to carry out this part.''.

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

(1) in subsection (a)(6), by striking ''paragraph'' and all that follows through ''subsection (c)''

and inserting ''paragraph (2), (4), (5), (6), (7), (8), (9), (10), or (11) of subsection (c)''; and

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

''(11) HEALTH COVERAGE PARTICIPATION REQUIREMENTS.—

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

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

''(C) LIMITATIONS ON AMOUNT OF PENALTY.—

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

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

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

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

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

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

''(II) $500,000.

''(D) ADVANCE NOTIFICATION OF FAILURE PRIOR TO ASSESSMENT.—Before a reasonable time prior to the assessment of any penalty under this paragraph with respect to any failure by an employer, the Secretary shall inform the employer in writing of such failure and shall provide the employer information regarding efforts and procedures which may be undertaken by the employer to correct such failure.

''(E) COORDINATION WITH EXCISE TAX.—Under regulations prescribed in accordance with section 424 of the , the Secretary and the

Secretary of the Treasury shall coordinate the assessment of penalties under this section in connection with failures to satisfy health coverage participation requirements with the imposition of excise taxes on such failures under section 4980H(b) of the Internal Revenue Code of 1986 so as to avoid duplication of penalties with respect to such failures.

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

(c) CLERICAL AMENDMENTS.—The table of contents in section 1 of such Act is amended by inserting after the item relating to section 734 the following new items:

''PART 8—NATIONAL HEALTH COVERAGE PARTICIPATION REQUIREMENTS

''Sec. 801. Election of employer to be subject to national health coverage participation requirements.
''Sec. 802. Treatment of coverage resulting from election.
''Sec. 803. Health coverage participation requirements.
''Sec. 804. Rules for applying requirements.
''Sec. 805. Termination of election in cases of substantial noncompliance.
''Sec. 806. Regulations.''.

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

SEC. 422. SATISFACTION OF HEALTH COVERAGE PARTICIPATION REQUIREMENTS UNDER THE INTERNAL REVENUE CODE OF 1986.

(a) FAILURE TO ELECT, OR SUBSTANTIALLY COMPLY WITH, HEALTH COVERAGE PARTICIPATION REQUIREMENTS.—For employment tax on employers who fail to elect, or substantially comply with, the health coverage participation requirements described in part 1, see section 3111(c) of the Internal Revenue Code of 1986 (as added by section 512 of this Act).

(b) OTHER FAILURES.—For excise tax on other failures of electing employers to comply with such requirements, see section 4980H of the Internal Revenue Code of 1986 (as added by section 511 of this Act).

SEC. 423. SATISFACTION OF HEALTH COVERAGE PARTICIPATION REQUIREMENTS UNDER THE PUBLIC HEALTH SERVICE ACT.

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

"SEC. 2793. NATIONAL HEALTH COVERAGE PARTICIPATION REQUIREMENTS.

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

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

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

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

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

''(A) such election shall be treated as the establishment and maintenance of a group health plan for purposes of this title, subject to section 251 of the Affordable Health Care for America Act; and

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

''(2) PERIODIC INVESTIGATIONS TO DETERMINE COMPLIANCE WITH HEALTH COVERAGE PARTICIPATION REQUIREMENTS.—The Secretary shall regularly audit a representative sampling of employers and conduct investigations and other activities with respect to such sampling of employers so as to dis-

cover noncompliance with the health coverage participation requirements in connection with such employers (during any period with respect to which an election under subsection (a) is in effect). The Secretary shall communicate findings of noncompliance made by the Secretary under this subsection to the Secretary of the Treasury and the Health Choices Commissioner. The Secretary shall take such timely enforcement action as appropriate to achieve compliance.

''(3) RECORDKEEPING.—To facilitate the audits described in subsection (b), the Secretary shall promulgate recordkeeping requirements for employers to account for both employees of the employer and individuals whom the employer has not treated as employees of the employer but with whom the employer, in the course of its trade or business, has engaged for the performance of labor or services. The scope and content of such recordkeeping requirements shall be determined by the Secretary and shall be designed to ensure that employees who are not properly treated as such may be identified and properly treated.

''(c) HEALTH COVERAGE PARTICIPATION REQUIREMENTS.—For purposes of this section, the term 'health

coverage participation requirements' means the requirements of part 1 of subtitle B of title IV of division A of the (as in effect on the date of the enactment of this section).

''(d) SEPARATE ELECTIONS.—Under regulations prescribed by the Secretary, separate elections may be made under subsection (a) with respect to full-time employees and employees who are not full-time employees.

''(e) TERMINATION OF ELECTION IN CASES OF SUBSTANTIAL NONCOMPLIANCE.—The Secretary may terminate the election of any employer under subsection (a) if the Secretary (in coordination with the Health Choices Commissioner) determines that such employer is in substantial noncompliance with the health coverage participation requirements and shall refer any such determination to the Secretary of the Treasury as appropriate.

''(f) ENFORCEMENT OF HEALTH COVERAGE PARTICIPATION REQUIREMENTS.—

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

date such failure first occurs and ending on the date such failure is corrected.

''(2) LIMITATIONS ON AMOUNT OF PENALTY.—

''(A) PENALTY NOT TO APPLY WHERE FAILURE NOT DISCOVERED EXERCISING REASONABLE DILIGENCE.—No penalty shall be assessed under paragraph (1) with respect to any failure during any period for which it is established to the satisfaction of the Secretary that the employer did not know, or exercising reasonable diligence would not have known, that such failure existed.

''(B) PENALTY NOT TO APPLY TO FAILURES CORRECTED WITHIN 30 DAYS.—No penalty shall be assessed under paragraph (1) with respect to any failure if—

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

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

''(C) OVERALL LIMITATION FOR UNINTENTIONAL FAILURES.—In the case of failures

which are due to reasonable cause and not to willful neglect, the penalty assessed under paragraph (1) for failures during any 1-year period shall not exceed the amount equal to the lesser of—

''(i) 10 percent of the aggregate amount paid or incurred by the employer (or predecessor employer) during the preceding taxable year for group health plans, or

''(ii) $500,000.

''(3) ADVANCE NOTIFICATION OF FAILURE PRIOR TO ASSESSMENT.—Before a reasonable time prior to the assessment of any penalty under paragraph (1) with respect to any failure by an employer, the Secretary shall inform the employer in writing of such failure and shall provide the employer information regarding efforts and procedures which may be undertaken by the employer to correct such failure.

''(4) ACTIONS TO ENFORCE ASSESSMENTS.—The Secretary may bring a civil action in any District Court of the United States to collect any civil penalty under this subsection.

''(5) COORDINATION WITH EXCISE TAX.—Under regulations prescribed in accordance with section 424 of the , the Secretary and the Secretary of the Treasury shall coordinate the assessment of penalties under paragraph (1) in connection with failures to satisfy health coverage participation requirements with the imposition of excise taxes on such failures under section 4980H(b) of the Internal Revenue Code of 1986 so as to avoid duplication of penalties with respect to such failures.

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

''(g) REGULATIONS.—The Secretary may promulgate such regulations as may be necessary or appropriate to carry out the provisions of this section, in accordance with section 424(a) of the . The Secretary may promulgate any interim final rules as the Secretary determines are appropriate to carry out this section.''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to periods beginning after December 31, 2012.

SEC. 424. ADDITIONAL RULES RELATING TO HEALTH COVERAGE PARTICIPATION REQUIREMENTS.

(a) ASSURING COORDINATION.—The officers consisting of the Secretary of Labor, the Secretary of the Treasury, the Secretary of Health and Human Services, and the Health Choices Commissioner shall ensure, through the execution of an interagency memorandum of understanding among such officers, that—

(1) regulations, rulings, and interpretations issued by such officers relating to the same matter over which two or more of such officers have responsibility under subpart B of part 8 of subtitle B of title I of the Employee Retirement Income Security Act of 1974, section 4980H of the Internal Revenue Code of 1986, and section 2793 of the Public Health Service Act are administered so as to have the same effect at all times; and

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

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

with subsection (a) by the officers referred to in subsection (a) shall provide for the application of the health coverage participation requirements to the plan sponsor and contributing employers of such plan. For purposes of this division, contributions made pursuant to a collective bargaining agreement or other agreement to such a group health plan shall be treated as amounts paid by the employer.

TITLE V—AMENDMENTS TO INTERNAL REVENUE CODE OF 1986

Subtitle A—Provisions Relating to Health Care Reform

PART 1—SHARED RESPONSIBILITY

Subpart A—Individual Responsibility

SEC. 501. TAX ON INDIVIDUALS WITHOUT ACCEPTABLE HEALTH CARE COVERAGE.

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

"PART VIII—HEALTH CARE RELATED TAXES

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

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

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

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

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

''(1) the taxpayer's modified adjusted gross income for the taxable year, over

''(2) the amount of gross income specified in section 6012(a)(1) with respect to the taxpayer.

''(b) LIMITATIONS.—

''(1) TAX LIMITED TO AVERAGE PREMIUM.—

''(A) IN GENERAL.—The tax imposed under subsection (a) with respect to any taxpayer for any taxable year shall not exceed the applicable national average premium for such taxable year.

''(B) APPLICABLE NATIONAL AVERAGE PREMIUM.—

''(i) IN GENERAL.—For purposes of subparagraph (A), the 'applicable national average premium' means, with respect to any taxable year, the average premium (as determined by the Secretary, in coordination with the Health Choices Commissioner) for self-only coverage under a basic

plan which is offered in a Health Insurance Exchange for the calendar year in which such taxable year begins.

''(ii) FAILURE TO PROVIDE COVERAGE FOR MORE THAN ONE INDIVIDUAL.—In the case of any taxpayer who fails to meet the requirements of subsection (d) with respect to more than one individual during the taxable year, clause (i) shall be applied by substituting 'family coverage' for 'self-only coverage'.

''(2) PRORATION FOR PART YEAR FAILURES.—The tax imposed under subsection (a) with respect to any taxpayer for any taxable year shall not exceed the amount which bears the same ratio to the amount of tax so imposed (determined without regard to this paragraph and after application of paragraph (1)) as—

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

''(B) the entire taxable year.

''(e) EXCEPTIONS.—

''(1) DEPENDENTS.—Subsection (a) shall not apply to any individual for any taxable year if a deduction is allowable under section 151 with respect to such individual to another taxpayer for any taxable year beginning in the same calendar year as such taxable year.

''(2) NONRESIDENT ALIENS.—Subsection (a) shall not apply to any individual who is a nonresident alien.

''(3) INDIVIDUALS RESIDING OUTSIDE UNITED STATES.—Any qualified individual (as defined in section 911(d)) (and any qualifying child residing with such individual) shall be treated for purposes of this section as covered by acceptable coverage during the period described in subparagraph (A) or (B) of section 911(d)(1), whichever is applicable.

''(4) INDIVIDUALS RESIDING IN POSSESSIONS OF THE UNITED STATES.—Any individual who is a bona fide resident of any possession of the United States (as determined under section 937(a)) for any taxable year (and any qualifying child residing with such individual) shall be treated for purposes of this section as covered by acceptable coverage during such taxable year.

''(5) RELIGIOUS CONSCIENCE EXEMPTION.—

''(A) IN GENERAL.—Subsection (a) shall not apply to any individual (and any qualifying child residing with such individual) for any period if such individual has in effect an exemption which certifies that such individual is a member of a recognized religious sect or division thereof described in section 1402(g)(1) and an adherent of established tenets or teachings of such sect or division as described in such section.

''(B) EXEMPTION.—An application for the exemption described in subparagraph (A) shall be filed with the Secretary at such time and in such form and manner as the Secretary may prescribe. The Secretary may treat an application for exemption under section 1402(g)(1) as an application for exemption under this section, or may otherwise coordinate applications under such sections, as the Secretary determines appropriate. Any such exemption granted by the Secretary shall be effective for such period as the Secretary determines appropriate.

''(d) ACCEPTABLE COVERAGE REQUIREMENT.—

''(1) IN GENERAL.—The requirements of this subsection are met with respect to any individual for

any period if such individual (and each qualifying child of such individual) is covered by acceptable coverage at all times during such period.

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

''(A) QUALIFIED HEALTH BENEFITS PLAN COVERAGE.—Coverage under a qualified health benefits plan (as defined in section 100(c) of the).

''(B) GRANDFATHERED HEALTH INSURANCE COVERAGE; COVERAGE UNDER GRANDFATHERED EMPLOYMENT-BASED HEALTH PLAN.—Coverage under a grandfathered health insurance coverage (as defined in subsection (a) of section 202 of the) or under a current employment-based health plan (within the meaning of subsection (b) of such section).

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

''(D) MEDICAID.—Coverage for medical assistance under title XIX of the Social Security Act.

''(E) MEMBERS OF THE ARMED FORCES AND DEPENDENTS (INCLUDING TRICARE).—

Coverage under chapter 55 of title 10, United States Code, including similar coverage furnished under section 1781 of title 38 of such Code.

''(F) VA.—Coverage under the veteran's health care program under chapter 17 of title 38, United States Code.

''(G) MEMBERS OF INDIAN TRIBES.—Health care services made available through the Indian Health Service, a tribal organization (as defined in section 4 of the Indian Health Care Improvement Act), or an urban Indian organization (as defined in such section) to members of an Indian tribe (as defined in such section).

''(H) OTHER COVERAGE.—Such other health benefits coverage as the Secretary, in coordination with the Health Choices Commissioner, recognizes for purposes of this subsection.

''(e) OTHER DEFINITIONS AND SPECIAL RULES.—

''(1) QUALIFYING CHILD.—For purposes of this section, the term 'qualifying child' has the meaning given such term by section 152(c). With respect to any period during which health coverage for a child must be provided by an individual pursuant to a

child support order, such child shall be treated as a qualifying child of such individual (and not as a qualifying child of any other individual).

''(2) BASIC PLAN.—For purposes of this section, the term 'basic plan' has the meaning given such term under section 100(c) of the .

''(3) HEALTH INSURANCE EXCHANGE.—For purposes of this section, the term 'Health Insurance Exchange' has the meaning given such term under section 100(c) of the , including any State-based health insurance exchange approved for operation under section 308 of such Act.

''(4) FAMILY COVERAGE.—For purposes of this section, the term 'family coverage' means any coverage other than self-only coverage.

''(5) MODIFIED ADJUSTED GROSS INCOME.—For purposes of this section, the term 'modified adjusted gross income' means adjusted gross income increased by—

''(A) any amount excluded from gross income under section 911, and

''(B) any amount of interest received or accrued by the taxpayer during the taxable year which is exempt from tax.

''(6) NOT TREATED AS TAX IMPOSED BY THIS CHAPTER FOR CERTAIN PURPOSES.—The tax imposed under this section shall not be treated as tax imposed by this chapter for purposes of determining the amount of any credit under this chapter or for purposes of section 55.

''(f) REGULATIONS.—The Secretary shall prescribe such regulations or other guidance as may be necessary or appropriate to carry out the purposes of this section, including regulations or other guidance (developed in coordination with the Health Choices Commissioner) which provide—

''(1) exemption from the tax imposed under subsection (a) in cases of de minimis lapses of acceptable coverage, and

''(2) a waiver of the application of subsection (a) in cases of hardship, including a process for applying for such a waiver.''.

(b) INFORMATION REPORTING.—

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

"SEC. 6050X. RETURNS RELATING TO HEALTH INSURANCE COVERAGE.

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

"(b) FORM AND MANNER OF RETURNS.—A return is described in this subsection if such return—

"(1) is in such form as the Secretary may prescribe, and

"(2) contains—

"(A) the name, address, and TIN of the primary insured and the name of each other individual obtaining coverage under the policy,

"(B) the period for which each such individual was provided with the coverage referred to in subsection (a), and

"(C) such other information as the Secretary may require.

"(c) STATEMENTS TO BE FURNISHED TO INDIVIDUALS WITH RESPECT TO WHOM INFORMATION IS REQUIRED.—Every person required to make a return under subsection (a) shall furnish to each primary insured whose

name is required to be set forth in such return a written statement showing—

''(1) the name and address of the person required to make such return and the phone number of the information contact for such person, and

''(2) the information required to be shown on the return with respect to such individual.

The written statement required under the preceding sentence shall be furnished on or before January 31 of the year following the calendar year for which the return under subsection (a) is required to be made.

''(d) COVERAGE PROVIDED BY GOVERNMENTAL UNITS.—In the case of coverage provided by any 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 (FF) and inserting '', or'', and by inserting after subparagraph (FF) the following new subparagraph:

''(GG) section 6050X (relating to returns relating to health insurance coverage).''.

(c) RETURN REQUIREMENT.—Subsection (a) of section 6012 of such Code is amended by inserting after paragraph (9) the following new paragraph:

''(10) Every individual to whom section 59B(a) applies and who fails to meet the requirements of section 59B(d) with respect to such individual or any qualifying child (as defined in section 152(c)) of such individual.''.

(d) CLERICAL AMENDMENTS.—

(1) The table of parts for subchapter A of chapter 1 of the Internal Revenue Code of 1986 is amended by adding at the end the following new item:

''PART VIII. HEALTH CARE RELATED TAXES.''.

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

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

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

(f) EFFECTIVE DATE.—

(1) IN GENERAL.—The amendments made by this section shall apply to taxable years beginning after December 31, 2012.

(2) RETURNS.—The amendments made by subsection (b) shall apply to calendar years beginning after December 31, 2012.

Subpart B—Employer Responsibility

SEC. 511. ELECTION TO SATISFY HEALTH COVERAGE PARTICIPATION REQUIREMENTS.

(a) IN GENERAL.—Chapter 43 of the Internal Revenue Code of 1986 is amended by adding at the end the following new section:

"SEC. 4980H. ELECTION WITH RESPECT TO HEALTH COVERAGE PARTICIPATION REQUIREMENTS.

"(a) ELECTION OF EMPLOYER RESPONSIBILITY TO PROVIDE HEALTH COVERAGE.—

''(1) IN GENERAL.—Subsection (b) shall apply to any employer with respect to whom an election under paragraph (2) is in effect.

''(2) TIME AND MANNER.—An employer may make an election under this paragraph at such time and in such form and manner as the Secretary may prescribe.

''(3) AFFILIATED GROUPS.—In the case of any employer which is part of a group of employers who are treated as a single employer under subsection (b), (c), (m), or (o) of section 414, the election under paragraph (2) shall be made by such person as the Secretary may provide. Any such election, once made, shall apply to all members of such group.

''(4) SEPARATE ELECTIONS.—Under regulations prescribed by the Secretary, separate elections may be made under paragraph (2) with respect to—

''(A) separate lines of business, and

''(B) full-time employees and employees who are not full-time employees.

''(5) TERMINATION OF ELECTION IN CASES OF SUBSTANTIAL NONCOMPLIANCE.—The Secretary may terminate the election of any employer under paragraph (2) if the Secretary (in coordination with

the Health Choices Commissioner) determines that such employer is in substantial noncompliance with the health coverage participation requirements.

''(b) EXCISE TAX WITH RESPECT TO FAILURE TO MEET HEALTH COVERAGE PARTICIPATION REQUIREMENTS.—

''(1) IN GENERAL.—In the case of any employer who fails (during any period with respect to which the election under subsection (a) is in effect) to satisfy the health coverage participation requirements with respect to any employee to whom such election applies, there is hereby imposed on each such failure with respect to each such employee a tax of $100 for each day in the period beginning on the date such failure first occurs and ending on the date such failure is corrected.

''(2) LIMITATIONS ON AMOUNT OF TAX.—

''(A) TAX NOT TO APPLY WHERE FAILURE NOT DISCOVERED EXERCISING REASONABLE DILIGENCE.—No tax shall be imposed by paragraph (1) on any failure during any period for which it is established to the satisfaction of the Secretary that the employer neither knew, nor exercising reasonable diligence would have known, that such failure existed.

''(B) TAX NOT TO APPLY TO FAILURES CORRECTED WITHIN 30 DAYS.—No tax shall be imposed by paragraph (1) on any failure if—

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

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

''(C) OVERALL LIMITATION FOR UNINTENTIONAL FAILURES.—In the case of failures which are due to reasonable cause and not to willful neglect, the tax imposed by subsection (a) for failures during the taxable year of the employer shall not exceed the amount equal to the lesser of—

''(i) 10 percent of the aggregate amount paid or incurred by the employer (or predecessor employer) during the preceding taxable year for employment-based health plans, or

''(ii) $500,000.

''(D) COORDINATION WITH OTHER ENFORCEMENT PROVISIONS.—The tax imposed

under paragraph (1) with respect to any failure shall be reduced (but not below zero) by the amount of any civil penalty collected under section 502(c)(11) of the Employee Retirement Income Security Act of 1974 or section 2793(g) of the Public Health Service Act with respect to such failure.

''(c) HEALTH COVERAGE PARTICIPATION REQUIREMENTS.—For purposes of this section, the term 'health coverage participation requirements' means the requirements of part I of subtitle B of title IV of the (as in effect on the date of the enactment of this section).''.

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

''Sec. 4980H. Election with respect to health coverage participation requirements.''.

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

SEC. 512. HEALTH CARE CONTRIBUTIONS OF NON-ELECTING EMPLOYERS.

(a) IN GENERAL.—Section 3111 of the Internal Revenue Code of 1986 is amended by redesignating subsection (c) as subsection (d) and by inserting after subsection (b) the following new subsection:

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

''(1) IN GENERAL.—In addition to other taxes, there is hereby imposed on every nonelecting employer an excise tax, with respect to having individuals in his employ, equal to 8 percent of the wages (as defined in section 3121(a)) paid by him with respect to employment (as defined in section 3121(b)).

''(2) SPECIAL RULES FOR SMALL EMPLOYERS.—

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

''If the annual payroll of such employer for the preceding calendar year:	**The applicable percentage is:**
Does not exceed $500,000	0 percent
Exceeds $500,000, but does not exceed $585,000	2 percent
Exceeds $585,000, but does not exceed $670,000	4 percent
Exceeds $670,000, but does not exceed $750,000	6 percent

''(B) SMALL EMPLOYER.—For purposes of this paragraph, the term 'small employer' means any employer for any calendar year if the annual payroll of such employer for the preceding calendar year does not exceed $750,000.

''(C) ANNUAL PAYROLL.—For purposes of this paragraph, the term 'annual payroll' means, with respect to any employer for any calendar year, the aggregate wages (as defined in section 3121(a)) paid by him with respect to employment (as defined in section 3121(b)) during such calendar year.

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

''(4) SPECIAL RULE FOR SEPARATE ELECTIONS.—In the case of an employer who makes a separate election described in section 4980H(a)(4) for any period, paragraph (1) shall be applied for such period by taking into account only the wages paid to employees who are not subject to such election.

''(5) AGGREGATION; PREDECESSORS.—For purposes of this subsection—

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

''(B) any reference to any person shall be treated as including a reference to any predecessor of such person.''.

(b) DEFINITIONS.—Section 3121 of such Code is amended by adding at the end the following new subsection:

''(aa) SPECIAL RULES FOR TAX ON EMPLOYERS ELECTING NOT TO PROVIDE HEALTH BENEFITS.—For purposes of section 3111(e)—

''(1) Paragraphs (1), (5), and (19) of subsection (b) shall not apply.

''(2) Paragraph (7) of subsection (b) shall apply by treating all services as not covered by the retirement systems referred to in subparagraphs (C) and (F) thereof.

''(3) Subsection (e) shall not apply and the term 'State' shall include the District of Columbia.''.

(c) CONFORMING AMENDMENT.—Subsection (d) of section 3111 of such Code, as redesignated by this section, is amended by striking ''this section'' and inserting ''subsections (a) and (b)''.

(d) APPLICATION TO RAILROADS.—

(1) IN GENERAL.—Section 3221 of such Code is amended by redesignating subsection (e) as sub-

section (d) and by inserting after subsection (b) the following new subsection:

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

''(1) IN GENERAL.—In addition to other taxes, there is hereby imposed on every nonelecting employer an excise tax, with respect to having individuals in his employ, equal to 8 percent of the compensation paid during any calendar year by such employer for services rendered to such employer.

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

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

''(4) SPECIAL RULE FOR SEPARATE ELECTIONS.—In the case of an employer who makes a separate election described in section 4980H(a)(4) for any period, subsection (a) shall be applied for such period by taking into account only the compensation paid to employees who are not subject to such election.''.

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

''(13) SPECIAL RULES FOR TAX ON EMPLOYERS ELECTING NOT TO PROVIDE HEALTH BENEFITS.—For purposes of section 3221(e)—

''(A) Paragraph (1) shall be applied without regard to the third sentence thereof.

''(B) Paragraph (2) shall not apply.''.

(3) CONFORMING AMENDMENT.—Subsection (d) of section 3221 of such Code, as redesignated by this section, is amended by striking ''subsections (a) and (b), see section 3231(e)(2)'' and inserting ''this section, see paragraphs (2) and (13)(B) of section 3231(e)''.

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

PART 2—CREDIT FOR SMALL BUSINESS EMPLOYEE HEALTH COVERAGE EXPENSES

SEC. 521. CREDIT FOR SMALL BUSINESS EMPLOYEE HEALTH COVERAGE EXPENSES.

(a) IN GENERAL.—Subpart D of part IV of subchapter A of chapter 1 of the Internal Revenue Code of

1986 (relating to business-related credits) is amended by adding at the end the following new section:

"SEC. 45R. SMALL BUSINESS EMPLOYEE HEALTH COVERAGE CREDIT.

"(a) IN GENERAL.—For purposes of section 38, in the case of a qualified small employer, the small business employee health coverage credit determined under this section for the taxable year is an amount equal to the applicable percentage of the qualified employee health coverage expenses of such employer for such taxable year.

"(b) APPLICABLE PERCENTAGE.—

"(1) IN GENERAL.—For purposes of this section, the applicable percentage is 50 percent.

"(2) PHASEOUT BASED ON AVERAGE COMPENSATION OF EMPLOYEES.—In the case of an employer whose average annual employee compensation for the taxable year exceeds $20,000, the percentage specified in paragraph (1) shall be reduced by a number of percentage points which bears the same ratio to 50 as such excess bears to $20,000.

"(c) LIMITATIONS.—

"(1) PHASEOUT BASED ON EMPLOYER SIZE.—In the case of an employer who employs more than 10 qualified employees during the taxable year, the credit determined under subsection (a) shall be re-

duced by an amount which bears the same ratio to the amount of such credit (determined without regard to this paragraph and after the application of the other provisions of this section) as—

''(A) the excess of—

''(i) the number of qualified employees employed by the employer during the taxable year, over

''(ii) 10, bears to

''(B) 15.

''(2) CREDIT NOT ALLOWED WITH RESPECT TO CERTAIN HIGHLY COMPENSATED EMPLOYEES.—No credit shall be determined under subsection (a) with respect to qualified employee health coverage expenses paid or incurred with respect to any employee for any taxable year if the aggregate compensation paid by the employer to such employee during such taxable year exceeds $80,000.

''(3) CREDIT ALLOWED FOR ONLY 2 TAXABLE YEARS.—No credit shall be determined under subsection (a) with respect to any employer for any taxable year unless the employer elects to have this section apply for such taxable year. An employer may elect the application of this section with respect to not more than 2 taxable years.

''(d) QUALIFIED EMPLOYEE HEALTH COVERAGE EXPENSES.—For purposes of this section—

''(1) IN GENERAL.—The term 'qualified employee health coverage expenses' means, with respect to any employer for any taxable year, the aggregate amount paid or incurred by such employer during such taxable year for coverage of any qualified employee of the employer (including any family coverage which covers such employee) under qualified health coverage.

''(2) QUALIFIED HEALTH COVERAGE.—The term 'qualified health coverage' means acceptable coverage (as defined in section 59B(d)) which—

''(A) is provided pursuant to an election under section 4980H(a), and

''(B) satisfies the requirements referred to in section 4980H(c).

''(e) OTHER DEFINITIONS.—For purposes of this section—

''(1) QUALIFIED SMALL EMPLOYER.—For purposes of this section, the term 'qualified small employer' means any employer for any taxable year if—

''(A) the number of qualified employees employed by such employer during the taxable year does not exceed 25, and

''(B) the average annual employee compensation of such employer for such taxable year does not exceed the sum of the dollar amounts in effect under subsection (b)(2).

''(2) QUALIFIED EMPLOYEE.—The term 'qualified employee' means any employee of an employer for any taxable year of the employer if such employee received at least $5,000 of compensation from such employer for services performed in the trade or business of such employer during such taxable year.

''(3) AVERAGE ANNUAL EMPLOYEE COMPENSATION.—The term 'average annual employee compensation' means, with respect to any employer for any taxable year, the average amount of compensation paid by such employer to qualified employees of such employer during such taxable year.

''(4) COMPENSATION.—The term 'compensation' has the meaning given such term in section 408(p)(6)(A).

''(5) FAMILY COVERAGE.—The term 'family coverage' means any coverage other than self-only coverage.

''(f) SPECIAL RULES.—For purposes of this section—

''(1) SPECIAL RULE FOR PARTNERSHIPS AND SELF-EMPLOYED.—In the case of a partnership (or a trade or business carried on by an individual) which has one or more qualified employees (determined without regard to this paragraph) with respect to whom the election under section 4980H(a) applies, each partner (or, in the case of a trade or business carried on by an individual, such individual) shall be treated as an employee.

''(2) AGGREGATION RULE.—All persons treated as a single employer under subsection (b), (c), (m), or (o) of section 414 shall be treated as 1 employer.

''(3) PREDECESSORS.—Any reference in this section to an employer shall include a reference to any predecessor of such employer.

''(4) DENIAL OF DOUBLE BENEFIT.—Any deduction otherwise allowable with respect to amounts paid or incurred for health insurance coverage to which subsection (a) applies shall be reduced by the amount of the credit determined under this section.

''(5) INFLATION ADJUSTMENT.—In the case of any taxable year beginning after 2013, each of the

dollar amounts in subsections (b)(2), (c)(2), and (e)(2) shall be increased by an amount equal to—

''(A) such dollar amount, multiplied by

''(B) the cost of living adjustment determined under section 1(f)(3) for the calendar year in which the taxable year begins determined by substituting 'calendar year 2012' for 'calendar year 1992' in subparagraph (B) thereof.

If any increase determined under this paragraph is not a multiple of $50, such increase shall be rounded to the next lowest multiple of $50.''.

(b) CREDIT TO BE PART OF GENERAL BUSINESS CREDIT.—Subsection (b) of section 38 of such Code (relating to general business credit) is amended by striking ''plus'' at the end of paragraph (34), by striking the period at the end of paragraph (35) and inserting '', plus'' , and by adding at the end the following new paragraph:

''(36) in the case of a qualified small employer (as defined in section 45R(e)), the small business employee health coverage credit determined under section 45R(a).''.

(c) CLERICAL AMENDMENT.—The table of sections for subpart D of part IV of subchapter A of chapter 1

of such Code is amended by inserting after the item relating to section 45Q the following new item:

''Sec. 45R. Small business employee health coverage credit.''.

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

PART 3—LIMITATIONS ON HEALTH CARE RELATED EXPENDITURES

SEC. 531. DISTRIBUTIONS FOR MEDICINE QUALIFIED ONLY IF FOR PRESCRIBED DRUG OR INSULIN.

(a) HSAS.—Subparagraph (A) of section 223(d)(2) of the Internal Revenue Code of 1986 is amended by adding at the end the following: ''Such term shall include an amount paid for medicine or a drug only if such medicine or drug is a prescribed drug or is insulin.''.

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

(c) HEALTH FLEXIBLE SPENDING ARRANGEMENTS AND HEALTH REIMBURSEMENT ARRANGEMENTS.—Section 106 of such Code is amended by adding at the end the following new subsection:

''(f) REIMBURSEMENTS FOR MEDICINE RESTRICTED TO PRESCRIBED DRUGS AND INSULIN.—For purposes of

this section and section 105, reimbursement for expenses incurred for a medicine or a drug shall be treated as a reimbursement for medical expenses only if such medicine or drug is a prescribed drug or is insulin.''.

(d) EFFECTIVE DATES.—The amendment made by this section shall apply to expenses incurred after December 31, 2010.

SEC. 532. LIMITATION ON HEALTH FLEXIBLE SPENDING ARRANGEMENTS UNDER CAFETERIA PLANS.

(a) IN GENERAL.—Section 125 of the Internal Revenue Code of 1986 is amended—

(1) by redesignating subsections (i) and (j) as subsections (j) and (k), respectively, and

(2) by inserting after subsection (h) the following new subsection:

''(i) LIMITATION ON HEALTH FLEXIBLE SPENDING ARRANGEMENTS.—

''(1) IN GENERAL.—For purposes of this section, if a benefit is provided under a cafeteria plan through employer contributions to a health flexible spending arrangement, such benefit shall not be treated as a qualified benefit unless the cafeteria plan provides that an employee may not elect for any taxable year to have salary reduction contributions in excess of $2,500 made to such arrangement.

''(2) INFLATION ADJUSTMENT.—In the case of any taxable year beginning after 2013, the dollar amount in paragraph (1) shall be increased by an amount equal to—

''(A) such dollar amount, multiplied by

''(B) the cost of living adjustment determined under section 1(f)(3) for the calendar year in which the taxable year begins determined by substituting 'calendar year 2012' for 'calendar year 1992' in subparagraph (B) thereof.

If any increase determined under this paragraph is not a multiple of $50, such increase shall be rounded to the next lowest multiple of $50.''.

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

SEC. 533. INCREASE IN PENALTY FOR NONQUALIFIED DISTRIBUTIONS FROM HEALTH SAVINGS ACCOUNTS.

(a) IN GENERAL.—Subparagraph (A) of section 223(f)(4) of the Internal Revenue Code of 1986 is amended by striking ''10 percent'' and inserting ''20 percent''.

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to taxable years beginning after December 31, 2010.

SEC. 534. DENIAL OF DEDUCTION FOR FEDERAL SUBSIDIES FOR PRESCRIPTION DRUG PLANS WHICH HAVE BEEN EXCLUDED FROM GROSS INCOME.

(a) IN GENERAL.—Section 139A of the Internal Revenue Code of 1986 is amended by striking the second sentence.

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to taxable years beginning after December 31, 2010.

PART 4—OTHER PROVISIONS TO CARRY OUT HEALTH INSURANCE REFORM

SEC. 541. DISCLOSURES TO CARRY OUT HEALTH INSURANCE EXCHANGE SUBSIDIES.

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

''(21) DISCLOSURE OF RETURN INFORMATION TO CARRY OUT HEALTH INSURANCE EXCHANGE SUBSIDIES.—

''(A) IN GENERAL.—The Secretary, upon written request from the Health Choices Com-

missioner or the head of a State-based health insurance exchange approved for operation under section 308 of the , shall disclose to officers and employees of the Health Choices Administration or such State-based health insurance exchange, as the case may be, return information of any taxpayer whose income is relevant in determining any affordability credit described in subtitle C of title III of the . Such return information shall be limited to—

''(i) taxpayer identity information with respect to such taxpayer,

''(ii) the filing status of such taxpayer,

''(iii) the modified adjusted gross income of such taxpayer (as defined in section 59B(e)(5)),

''(iv) the number of dependents of the taxpayer,

''(v) such other information as is prescribed by the Secretary by regulation as might indicate whether the taxpayer is eligible for such affordability credits (and the amount thereof), and

''(vi) the taxable year with respect to which the preceding information relates or, if applicable, the fact that such information is not available.

''(B) RESTRICTION ON USE OF DISCLOSED INFORMATION.—Return information disclosed under subparagraph (A) may be used by officers and employees of the Health Choices Administration or such State-based health insurance exchange, as the case may be, only for the purposes of, and to the extent necessary in, establishing and verifying the appropriate amount of any affordability credit described in subtitle C of title III of the and providing for the repayment of any such credit which was in excess of such appropriate amount.''.

(b) PROCEDURES AND RECORDKEEPING RELATED TO DISCLOSURES.—Paragraph (4) of section 6103(p) of such Code is amended—

(1) by inserting '', or any entity described in subsection (l)(21),'' after ''or (20)'' in the matter preceding subparagraph (A),

(2) by inserting ''or any entity described in subsection (l)(21),'' after ''or (o)(1)(A),'' in subparagraph (F)(ii), and

(3) by inserting ''or any entity described in subsection (l)(21),'' after ''or (20),'' both places it appears in the matter after subparagraph (F).

(c) UNAUTHORIZED DISCLOSURE OR INSPECTION.—Paragraph (2) of section 7213(a) of such Code is amended by striking ''or (20)'' and inserting ''(20), or (21)''.

SEC. 542. OFFERING OF EXCHANGE-PARTICIPATING HEALTH BENEFITS PLANS THROUGH CAFETERIA PLANS.

(a) IN GENERAL.—Subsection (f) of section 125 of the Internal Revenue Code of 1986 is amended by adding at the end the following new paragraph:

''(3) CERTAIN EXCHANGE-PARTICIPATING HEALTH BENEFITS PLANS NOT QUALIFIED.—

''(A) IN GENERAL.—The term 'qualified benefit' shall not include any exchange-participating health benefits plan (as defined in section 101(c) of the).

''(B) EXCEPTION FOR EXCHANGE-ELIGIBLE EMPLOYERS.—Subparagraph (A) shall not apply with respect to any employee if such employee's employer is an exchange-eligible employer (as defined in section 302 of the).''.

(b) CONFORMING AMENDMENTS.—Subsection (f) of section 125 of such Code is amended—

(1) by striking ''For purposes of this section, the term'' and inserting ''For purposes of this section—

''(1) IN GENERAL.—The term'', and

(2) by striking ''Such term shall not include'' and inserting the following:

''(2) LONG-TERM CARE INSURANCE NOT QUALIFIED.—The term 'qualified benefit' shall not include''.

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

SEC. 543. EXCLUSION FROM GROSS INCOME OF PAYMENTS MADE UNDER REINSURANCE PROGRAM FOR RETIREES.

(a) IN GENERAL.—Section 139A of the Internal Revenue Code of 1986 is amended—

(1) by striking ''Gross income'' and inserting the following:

''(a) FEDERAL SUBSIDIES FOR PRESCRIPTION DRUG PLANS.—Gross income'', and

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

''(b) FEDERAL REINSURANCE PROGRAM FOR RETIREES.—A rule similar to the rule of subsection (a) shall

apply with respect to payments made under section 111 of the Affordable Health Care for America Act.''.

(b) CONFORMING AMENDMENT.—The heading of section 139A of such Code (and the item relating to such section in the table of sections for part III of subchapter B of chapter 1 of such Code) is amended by inserting ''**AND RETIREE HEALTH PLANS**'' after ''**PRESCRIPTION DRUG PLANS**''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years ending after the date of the enactment of this Act.

SEC. 544. CLASS PROGRAM TREATED IN SAME MANNER AS LONG-TERM CARE INSURANCE.

(a) IN GENERAL.—Subsection (f) of section 7702B of the Internal Revenue Code of 1986 is amended—

(1) by striking ''State long-term care plan'' in paragraph (1)(A) and inserting ''government long-term care plan'',

(2) by redesignating paragraph (2) as paragraph (3), and

(3) by inserting after paragraph (2) the following new paragraph:

''(2) GOVERNMENT LONG-TERM CARE PLAN.—For purposes of this subsection, the term 'government long-term care plan' means—

''(A) the CLASS program established under title XXXII of the Public Health Service Act, and

''(B) any State long-term care plan.''.

(b) CONFORMING AMENDMENTS.—

(1) Paragraph (3) of section 7702B(f) of such Code, as redesignated by subsection (a), is amended by striking ''paragraph (1)'' and inserting ''this subsection''.

(2) Subsection (f) of section 7702(B) of such Code is amended by striking ''STATE-MAINTAINED'' in the heading thereof and inserting ''GOVERNMENT''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years ending after December 31, 2010.

SEC. 545. EXCLUSION FROM GROSS INCOME FOR MEDICAL CARE PROVIDED FOR INDIANS.

(a) IN GENERAL.—Part III of subchapter B of chapter 1 of the Internal Revenue Code of 1986 (relating to items specifically excluded from gross income) is amended by inserting after section 139C the following new section:

''SEC. 139D. MEDICAL CARE PROVIDED FOR INDIANS.

''(a) IN GENERAL.—Gross income does not include—

''(1) health services or benefits provided or purchased by the Indian Health Service, either directly or indirectly, through a grant to or a contract or compact with an Indian tribe or tribal organization or through programs of third parties funded by the Indian Health Service,

''(2) medical care provided by an Indian tribe or tribal organization to a member of an Indian tribe (including for this purpose, to the member's spouse or dependents) through any one of the following: provided or purchased medical care services; accident or health insurance (or an arrangement having the effect of accident or health insurance); or amounts paid, directly or indirectly, to reimburse the member for expenses incurred for medical care,

''(3) the value of accident or health plan coverage provided by an Indian tribe or tribal organization for medical care to a member of an Indian tribe (including for this purpose, coverage that extends to such member's spouse or dependents) under an accident or health plan (or through an arrangement having the effect of accident or health insurance), and

''(4) any other medical care provided by an Indian tribe that supplements, replaces, or substitutes

for the programs and services provided by the Federal Government to Indian tribes or Indians.

''(b) DEFINITIONS.—For purposes of this section—

''(1) IN GENERAL.—The terms 'accident or health insurance' and 'accident or health plan' have the same meaning as when used in sections 104 and 106.

''(2) MEDICAL CARE.—The term 'medical care' has the meaning given such term in section 213.

''(3) DEPENDENT.—The term 'dependent' has the meaning given such term in section 152, determined without regard to subsections (b)(1), (b)(2), and (d)(1)(B).

''(4) INDIAN TRIBE.—The term 'Indian tribe' means any Indian tribe, band, nation, pueblo, or other organized group or community, including any Alaska Native village, or regional or village corporation, as defined in, or established pursuant to, the Alaska Native Claims Settlement Act (43 U.S.C. 1601 et seq.), which is recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians.

''(5) TRIBAL ORGANIZATION.—The term 'tribal organization' has the meaning given such term in

section 4(l) of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450b(l)).''.

(b) CLERICAL AMENDMENT.—The table of sections for such part III is amended by inserting after the item relating to section 139C the following new item:

''Sec. 139D. Medical care provided for Indians.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to health benefits and coverage provided after the date of enactment of this Act.

(d) NO INFERENCE.—Nothing in the amendments made by this section shall be construed to create an inference with respect to the exclusion from gross income of—

(1) benefits provided by Indian tribes that are not within the scope of this section, and

(2) health benefits or coverage provided by Indian tribes prior to the effective date of this section.

Subtitle B—Other Revenue Provisions

PART 1—GENERAL PROVISIONS

SEC. 551. SURCHARGE ON HIGH INCOME INDIVIDUALS.

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

''Subpart B—Surcharge on High Income Individuals

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

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

"(a) GENERAL RULE.—In the case of a taxpayer other than a corporation, there is hereby imposed (in addition to any other tax imposed by this subtitle) a tax equal to 5.4 percent of so much of the modified adjusted gross income of the taxpayer as exceeds $1,000,000.

"(b) TAXPAYERS NOT MAKING A JOINT RETURN.—In the case of any taxpayer other than a taxpayer making a joint return under section 6013 or a surviving spouse (as defined in section 2(a)), subsection (a) shall be applied by substituting '$500,000' for '$1,000,000'.

"(c) MODIFIED ADJUSTED GROSS INCOME.—For purposes of this section, the term 'modified adjusted gross income' means adjusted gross income reduced by any deduction (not taken into account in determining adjusted gross income) allowed for investment interest (as defined in section 163(d)). In the case of an estate or trust, adjusted gross income shall be determined as provided in section 67(e).

"(d) SPECIAL RULES.—

"(1) NONRESIDENT ALIEN.—In the case of a nonresident alien individual, only amounts taken into account in connection with the tax imposed under section 871(b) shall be taken into account under this section.

''(2) CITIZENS AND RESIDENTS LIVING ABROAD.—The dollar amount in effect under subsection (a) (after the application of subsection (b)) shall be decreased by the excess of—

''(A) the amounts excluded from the taxpayer's gross income under section 911, over

''(B) the amounts of any deductions or exclusions disallowed under section 911(d)(6) with respect to the amounts described in subparagraph (A).

''(3) CHARITABLE TRUSTS.—Subsection (a) shall not apply to a trust all the unexpired interests in which are devoted to one or more of the purposes described in section 170(c)(2)(B).

''(4) NOT TREATED AS TAX IMPOSED BY THIS CHAPTER FOR CERTAIN PURPOSES.—The tax imposed under this section shall not be treated as tax imposed by this chapter for purposes of determining the amount of any credit under this chapter or for purposes of section 55.''.

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

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

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

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

SEC. 552. EXCISE TAX ON MEDICAL DEVICES.

(a) IN GENERAL.—Chapter 31 of the Internal Revenue Code of 1986 is amended by adding at the end the following new subchapter:

"Subchapter D—Medical Devices

"Sec. 4061. Medical devices.

"SEC. 4061. MEDICAL DEVICES.

"(a) IN GENERAL.—There is hereby imposed on the first taxable sale of any medical device a tax equal to 2.5 percent of the price for which so sold.

"(b) FIRST TAXABLE SALE.—For purposes of this section—

"(1) IN GENERAL.—The term 'first taxable sale' means the first sale, for a purpose other than for resale, after production, manufacture, or importation.

''(2) EXCEPTION FOR SALES AT RETAIL ESTABLISHMENTS.—Such term shall not include the sale of any medical device if—

''(A) such sale is made at a retail establishment on terms which are available to the general public, and

''(B) such medical device is of a type (and purchased in a quantity) which is purchased by the general public.

''(3) EXCEPTION FOR EXPORTS, ETC.—Rules similar to the rules of sections 4221 (other than paragraphs (3), (4), (5), and (6) of subsection (a) thereof) and 4222 shall apply for purposes of this section. To the extent provided by the Secretary, section 4222 may be extended to, and made applicable with respect to, the exemption provided by paragraph (2).

''(4) SALES TO PATIENTS NOT TREATED AS RESALES.—If a medical device is sold for use in connection with providing any health care service to an individual, such sale shall not be treated as being for the purpose of resale (even if such device is sold to such individual).

''(c) OTHER DEFINITIONS AND SPECIAL RULES.—For purposes of this section—

''(1) MEDICAL DEVICE.—The term 'medical device' means any device (as defined in section 201(h) of the Federal Food, Drug, and Cosmetic Act) intended for humans.

''(2) LEASE TREATED AS SALE.—Rules similar to the rules of section 4217 shall apply.

''(3) USE TREATED AS SALE.—

''(A) IN GENERAL.—If any person uses a medical device before the first taxable sale of such device, then such person shall be liable for tax under such subsection in the same manner as if such use were the first taxable sale of such device.

''(B) EXCEPTIONS.—The preceding sentence shall not apply to—

''(i) use of a medical device as material in the manufacture or production of, or as a component part of, another medical device to be manufactured or produced by such person, or

''(ii) use of a medical device after a sale described in subsection (b)(2).

''(4) DETERMINATION OF PRICE.—

''(A) IN GENERAL.—Rules similar to the rules of subsections (a), (c), and (d) of section 4216 shall apply for purposes of this section.

''(B) CONSTRUCTIVE SALE PRICE.—If—

''(i) a medical device is sold (otherwise than through an arm's length transaction) at less than the fair market price, or

''(ii) a person is liable for tax for a use described in paragraph (3),

the tax under this section shall be computed on the price for which such or similar devices are sold in the ordinary course of trade as determined by the Secretary.

''(5) RESALES PURSUANT TO CERTAIN CONTRACT ARRANGEMENTS.—

''(A) IN GENERAL.—In the case of a specified contract sale of a medical device, the seller referred to in subparagraph (B)(i) shall be entitled to recover from the producer, manufacturer, or importer referred to in subparagraph (B)(ii) the amount of the tax paid by such seller under this section with respect to such sale.

''(B) SPECIFIED CONTRACT SALE.—For purposes of this paragraph, the term 'specified contract sale' means, with respect to any med-

ical device, the first taxable sale of such device if—

''(i) the seller is not the producer, manufacturer, or importer of such device,

''(ii) the price at which such device is so sold is determined in accordance with a contract between the producer, manufacturer, or importer of such device and the person to whom such device is so sold.

''(C) SPECIAL RULES RELATED TO CREDITS AND REFUNDS.—In the case of any credit or refund under section 6416 of the tax imposed under this section on a specified contract sale of a medical device—

''(i) such credit or refund shall be allowed or made only if the seller has filed with the Secretary the written consent of the producer, manufacturer, or importer referred to in subparagraph (B)(ii) to the allowance of such credit or the making of such refund, and

''(ii) the amount of tax taken into account under subparagraph (A) shall be reduced by the amount of such credit or refund.''.

(b) CONFORMING AMENDMENTS.—

(1) Paragraph (2) of section 6416(b) of such Code is amended—

(A) by inserting ''or 4061'' after ''under section 4051'', and

(B) by adding at the end the following: ''In the case of the tax imposed by section 4061, subparagraphs (B), (C), (D), and (E) shall not apply.''.

(2) The table of subchapters for chapter 31 of such Code is amended by adding at the end the following new item:

''SUBCHAPTER D. MEDICAL DEVICES.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to sales (and leases and uses treated as sales) after December 31, 2012.

SEC. 553. EXPANSION OF INFORMATION REPORTING REQUIREMENTS.

(a) IN GENERAL.—Section 6041 of the Internal Revenue Code of 1986 is amended by adding at the end the following new subsections:

''(h) APPLICATION TO CORPORATIONS.—Notwithstanding any regulation prescribed by the Secretary before the date of the enactment of this subsection, for purposes of this section the term 'person' includes any corporation

that is not an organization exempt from tax under section 501(a).

''(i) REGULATIONS.—The Secretary may prescribe such regulations and other guidance as may be appropriate or necessary to carry out the purposes of this section, including rules to prevent duplicative reporting of transactions.''.

(b) PAYMENTS FOR PROPERTY AND OTHER GROSS PROCEEDS.—Subsection (a) of section 6041 of the Internal Revenue Code of 1986 is amended—

(1) by inserting ''amounts in consideration for property,'' after ''wages,'',

(2) by inserting ''gross proceeds,'' after ''emoluments, or other'', and

(3) by inserting ''gross proceeds,'' after ''setting forth the amount of such''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to payments made after December 31, 2011.

SEC. 554. DELAY IN APPLICATION OF WORLDWIDE ALLOCATION OF INTEREST.

(a) IN GENERAL.—Paragraphs (5)(D) and (6) of section 864(f) of the Internal Revenue Code of 1986 are each amended by striking ''December 31, 2010'' and inserting ''December 31, 2019''.

(b) TRANSITION.—Subsection (f) of section 864 of such Code is amended by striking paragraph (7).

PART 2—PREVENTION OF TAX AVOIDANCE

SEC. 561. LIMITATION ON TREATY BENEFITS FOR CERTAIN DEDUCTIBLE PAYMENTS.

(a) IN GENERAL.—Section 894 of the Internal Revenue Code of 1986 (relating to income affected by treaty) is amended by adding at the end the following new subsection:

''(d) LIMITATION ON TREATY BENEFITS FOR CERTAIN DEDUCTIBLE PAYMENTS.—

''(1) IN GENERAL.—In the case of any deductible related-party payment, any withholding tax imposed under chapter 3 (and any tax imposed under subpart A or B of this part) with respect to such payment may not be reduced under any treaty of the United States unless any such withholding tax would be reduced under a treaty of the United States if such payment were made directly to the foreign parent corporation.

''(2) DEDUCTIBLE RELATED-PARTY PAYMENT.—For purposes of this subsection, the term 'deductible related-party payment' means any payment made, directly or indirectly, by any person to any other person if the payment is allowable as a de-

duction under this chapter and both persons are members of the same foreign controlled group of entities.

''(3) FOREIGN CONTROLLED GROUP OF ENTITIES.—For purposes of this subsection—

''(A) IN GENERAL.—The term 'foreign controlled group of entities' means a controlled group of entities the common parent of which is a foreign corporation.

''(B) CONTROLLED GROUP OF ENTITIES.—The term 'controlled group of entities' means a controlled group of corporations as defined in section 1563(a)(1), except that—

''(i) 'more than 50 percent' shall be substituted for 'at least 80 percent' each place it appears therein, and

''(ii) the determination shall be made without regard to subsections (a)(4) and (b)(2) of section 1563.

A partnership or any other entity (other than a corporation) shall be treated as a member of a controlled group of entities if such entity is controlled (within the meaning of section 954(d)(3)) by members of such group (includ-

ing any entity treated as a member of such group by reason of this sentence).

''(4) FOREIGN PARENT CORPORATION.—For purposes of this subsection, the term 'foreign parent corporation' means, with respect to any deductible related-party payment, the common parent of the foreign controlled group of entities referred to in paragraph (3)(A).

''(5) REGULATIONS.—The Secretary may prescribe such regulations or other guidance as are necessary or appropriate to carry out the purposes of this subsection, including regulations or other guidance which provide for—

''(A) the treatment of two or more persons as members of a foreign controlled group of entities if such persons would be the common parent of such group if treated as one corporation, and

''(B) the treatment of any member of a foreign controlled group of entities as the common parent of such group if such treatment is appropriate taking into account the economic relationships among such entities.''.

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to payments made after the date of the enactment of this Act.

SEC. 562. CODIFICATION OF ECONOMIC SUBSTANCE DOCTRINE; PENALTIES.

(a) IN GENERAL.—Section 7701 of the Internal Revenue Code of 1986 is amended by redesignating subsection (o) as subsection (p) and by inserting after subsection (n) the following new subsection:

''(o) CLARIFICATION OF ECONOMIC SUBSTANCE DOCTRINE.—

''(1) APPLICATION OF DOCTRINE.—In the case of any transaction to which the economic substance doctrine is relevant, such transaction shall be treated as having economic substance only if—

''(A) the transaction changes in a meaningful way (apart from Federal income tax effects) the taxpayer's economic position, and

''(B) the taxpayer has a substantial purpose (apart from Federal income tax effects) for entering into such transaction.

''(2) SPECIAL RULE WHERE TAXPAYER RELIES ON PROFIT POTENTIAL.—

''(A) IN GENERAL.—The potential for profit of a transaction shall be taken into ac-

count in determining whether the requirements of subparagraphs (A) and (B) of paragraph (1) are met with respect to the transaction only if the present value of the reasonably expected pre-tax profit from the transaction is substantial in relation to the present value of the expected net tax benefits that would be allowed if the transaction were respected.

''(B) TREATMENT OF FEES AND FOREIGN TAXES.—Fees and other transaction expenses and foreign taxes shall be taken into account as expenses in determining pre-tax profit under subparagraph (A).

''(3) STATE AND LOCAL TAX BENEFITS.—For purposes of paragraph (1), any State or local income tax effect which is related to a Federal income tax effect shall be treated in the same manner as a Federal income tax effect.

''(4) FINANCIAL ACCOUNTING BENEFITS.—For purposes of paragraph (1)(B), achieving a financial accounting benefit shall not be taken into account as a purpose for entering into a transaction if the origin of such financial accounting benefit is a reduction of Federal income tax.

''(5) DEFINITIONS AND SPECIAL RULES.—For purposes of this subsection—

''(A) ECONOMIC SUBSTANCE DOCTRINE.—The term 'economic substance doctrine' means the common law doctrine under which tax benefits under subtitle A with respect to a transaction are not allowable if the transaction does not have economic substance or lacks a business purpose.

''(B) EXCEPTION FOR PERSONAL TRANSACTIONS OF INDIVIDUALS.—In the case of an individual, paragraph (1) shall apply only to transactions entered into in connection with a trade or business or an activity engaged in for the production of income.

''(C) OTHER COMMON LAW DOCTRINES NOT AFFECTED.—Except as specifically provided in this subsection, the provisions of this subsection shall not be construed as altering or supplanting any other rule of law, and the requirements of this subsection shall be construed as being in addition to any such other rule of law.

''(D) DETERMINATION OF APPLICATION OF DOCTRINE NOT AFFECTED.—The determination

of whether the economic substance doctrine is relevant to a transaction (or series of transactions) shall be made in the same manner as if this subsection had never been enacted.

''(6) REGULATIONS.—The Secretary shall prescribe such regulations as may be necessary or appropriate to carry out the purposes of this subsection.''.

(b) PENALTY FOR UNDERPAYMENTS ATTRIBUTABLE TO TRANSACTIONS LACKING ECONOMIC SUBSTANCE.—

(1) IN GENERAL.—Subsection (b) of section 6662 of such Code is amended by inserting after paragraph (5) the following new paragraph:

''(6) Any disallowance of claimed tax benefits by reason of a transaction lacking economic substance (within the meaning of section 7701(o)) or failing to meet the requirements of any similar rule of law.''.

(2) INCREASED PENALTY FOR NONDISCLOSED TRANSACTIONS.—Section 6662 of such Code is amended by adding at the end the following new subsection:

''(i) INCREASE IN PENALTY IN CASE OF NONDISCLOSED NONECONOMIC SUBSTANCE TRANSACTIONS.—

''(1) IN GENERAL.—In the case of any portion of an underpayment which is attributable to one or more nondisclosed noneconomic substance transactions, subsection (a) shall be applied with respect to such portion by substituting '40 percent' for '20 percent'.

''(2) NONDISCLOSED NONECONOMIC SUBSTANCE TRANSACTIONS.—For purposes of this subsection, the term 'nondisclosed noneconomic substance transaction' means any portion of a transaction described in subsection (b)(6) with respect to which the relevant facts affecting the tax treatment are not adequately disclosed in the return nor in a statement attached to the return.

''(3) SPECIAL RULE FOR AMENDED RETURNS.—Except as provided in regulations, in no event shall any amendment or supplement to a return of tax be taken into account for purposes of this subsection if the amendment or supplement is filed after the earlier of the date the taxpayer is first contacted by the Secretary regarding the examination of the return or such other date as is specified by the Secretary.''.

(3) CONFORMING AMENDMENT.—Subparagraph (B) of section 6662A(e)(2) of such Code is amended—

(A) by striking ''section 6662(h)'' and inserting ''subsections (h) or (i) of section 6662'', and

(B) by striking ''GROSS VALUATION MISSTATEMENT PENALTY'' in the heading and inserting ''CERTAIN INCREASED UNDERPAYMENT PENALTIES''.

(c) REASONABLE CAUSE EXCEPTION NOT APPLICABLE TO NONECONOMIC SUBSTANCE TRANSACTIONS AND TAX SHELTERS.—

(1) REASONABLE CAUSE EXCEPTION FOR UNDERPAYMENTS.—Subsection (c) of section 6664 of such Code is amended—

(A) by redesignating paragraphs (2) and (3) as paragraphs (3) and (4), respectively,

(B) by striking ''paragraph (2)'' in paragraph (4)(A), as so redesignated, and inserting ''paragraph (3)'', and

(C) by inserting after paragraph (1) the following new paragraph:

''(2) EXCEPTION.—Paragraph (1) shall not apply to any portion of an underpayment which is

attributable to one or more tax shelters (as defined in section 6662(d)(2)(C)) or transactions described in section 6662(b)(6).''.

(2) REASONABLE CAUSE EXCEPTION FOR REPORTABLE TRANSACTION UNDERSTATEMENTS.—Subsection (d) of section 6664 of such Code is amended—

(A) by redesignating paragraphs (2) and (3) as paragraphs (3) and (4), respectively,

(B) by striking ''paragraph (2)(C)'' in paragraph (4), as so redesignated, and inserting ''paragraph (3)(C)'', and

(C) by inserting after paragraph (1) the following new paragraph:

''(2) EXCEPTION.—Paragraph (1) shall not apply to any portion of a reportable transaction understatement which is attributable to one or more tax shelters (as defined in section 6662(d)(2)(C)) or transactions described in section 6662(b)(6).''.

(d) APPLICATION OF PENALTY FOR ERRONEOUS CLAIM FOR REFUND OR CREDIT TO NONECONOMIC SUBSTANCE TRANSACTIONS.—Section 6676 of such Code is amended by redesignating subsection (c) as subsection (d) and inserting after subsection (b) the following new subsection:

''(c) NONECONOMIC SUBSTANCE TRANSACTIONS TREATED AS LACKING REASONABLE BASIS.—For purposes of this section, any excessive amount which is attributable to any transaction described in section 6662(b)(6) shall not be treated as having a reasonable basis.''.

(e) EFFECTIVE DATE.—

(1) IN GENERAL.—Except as otherwise provided in this subsection, the amendments made by this section shall apply to transactions entered into after the date of the enactment of this Act.

(2) UNDERPAYMENTS.—The amendments made by subsections (b) and (c)(1) shall apply to underpayments attributable to transactions entered into after the date of the enactment of this Act.

(3) UNDERSTATEMENTS.—The amendments made by subsection (c)(2) shall apply to understatements attributable to transactions entered into after the date of the enactment of this Act.

(4) REFUNDS AND CREDITS.—The amendment made by subsection (d) shall apply to refunds and credits attributable to transactions entered into after the date of the enactment of this Act.

SEC. 563. CERTAIN LARGE OR PUBLICLY TRADED PERSONS MADE SUBJECT TO A MORE LIKELY THAN NOT STANDARD FOR AVOIDING PENALTIES ON UNDERPAYMENTS.

(a) IN GENERAL.—Subsection (c) of section 6664 of the Internal Revenue Code of 1986, as amended by section 562, is amended—

(1) by redesignating paragraphs (3) and (4) as paragraphs (4) and (5), respectively,

(2) by striking ''paragraph (3)'' in paragraph (4)(A), as so redesignated, and inserting ''paragraph (4)'', and

(3) by inserting after paragraph (2) the following new paragraph:

''(3) SPECIAL RULE FOR CERTAIN LARGE OR PUBLICLY TRADED PERSONS.—

''(A) IN GENERAL.—In the case of any specified person, paragraph (1) shall apply to the portion of an underpayment which is attributable to any item only if such person has a reasonable belief that the tax treatment of such item by such person is more likely than not the proper tax treatment of such item.

''(B) SPECIFIED PERSON.—For purposes of this paragraph, the term 'specified person' means—

''(i) any person required to file periodic or other reports under section 13 of the Securities Exchange Act of 1934, and

''(ii) any corporation with gross receipts in excess of $100,000,000 for the taxable year involved.

All persons treated as a single employer under section 52(a) shall be treated as one person for purposes of clause (ii).''.

(b) NONAPPLICATION OF SUBSTANTIAL AUTHORITY AND REASONABLE BASIS STANDARDS FOR REDUCING UNDERSTATEMENTS.—Paragraph (2) of section 6662(d) of such Code is amended by adding at the end the following new subparagraph:

''(D) REDUCTION NOT TO APPLY TO CERTAIN LARGE OR PUBLICLY TRADED PERSONS.—Subparagraph (B) shall not apply to any specified person (as defined in section 6664(c)(3)(B)).''.

(c) EFFECTIVE DATE.—

(1) IN GENERAL.—Except as provided in paragraph (2), the amendments made by this section shall apply to underpayments attributable to transactions entered into after the date of the enactment of this Act.

(2) NONAPPLICATION OF UNDERSTATEMENT REDUCTION.—The amendment made by subsection (b) shall apply to understatements attributable to transactions entered into after the date of the enactment of this Act.

PART 3—PARITY IN HEALTH BENEFITS

SEC. 571. CERTAIN HEALTH RELATED BENEFITS APPLICABLE TO SPOUSES AND DEPENDENTS EXTENDED TO ELIGIBLE BENEFICIARIES.

(a) APPLICATION OF ACCIDENT AND HEALTH PLANS TO ELIGIBLE BENEFICIARIES.—

(1) EXCLUSION OF CONTRIBUTIONS.—Section 106 of the Internal Revenue Code of 1986 (relating to contributions by employer to accident and health plans), as amended by section 531, is amended by adding at the end the following new subsection:

''(g) COVERAGE PROVIDED FOR ELIGIBLE BENEFICIARIES OF EMPLOYEES.—

''(1) IN GENERAL.—Subsection (a) shall apply with respect to any eligible beneficiary of the employee.

''(2) ELIGIBLE BENEFICIARY.—For purposes of this subsection, the term 'eligible beneficiary' means any individual who is eligible to receive benefits or coverage under an accident or health plan.''.

(2) EXCLUSION OF AMOUNTS EXPENDED FOR MEDICAL CARE.—The first sentence of section 105(b) of such Code (relating to amounts expended for medical care) is amended—

(A) by striking ''and his dependents'' and inserting ''his dependents'', and

(B) by inserting before the period the following: ''and any eligible beneficiary (within the meaning of section 106(g)) with respect to the taxpayer''.

(3) PAYROLL TAXES.—

(A) Section 3121(a)(2) of such Code is amended—

(i) by striking ''or any of his dependents'' in the matter preceding subparagraph (A) and inserting '', any of his dependents, or any eligible beneficiary (within the meaning of section 106(g)) with respect to the employee'',

(ii) by striking ''or any of his dependents,'' in subparagraph (A) and inserting '', any of his dependents, or any eligible beneficiary (within the meaning of section 106(g)) with respect to the employee,'', and

(iii) by striking ''and their dependents'' both places it appears and inserting ''and such employees' dependents and eligible beneficiaries (within the meaning of section 106(g))''.

(B) Section 3231(e)(1) of such Code is amended—

(i) by striking ''or any of his dependents'' and inserting '', any of his dependents, or any eligible beneficiary (within the meaning of section 106(g)) with respect to the employee,'', and

(ii) by striking ''and their dependents'' both places it appears and inserting ''and such employees' dependents and eligible beneficiaries (within the meaning of section 106(g))''.

(C) Section 3306(b)(2) of such Code is amended—

(i) by striking ''or any of his dependents'' in the matter preceding subparagraph (A) and inserting '', any of his dependents, or any eligible beneficiary (within the meaning of section 106(g)) with respect to the employee,'',

(ii) by striking ''or any of his dependents'' in subparagraph (A) and inserting '', any of his dependents, or any eligible beneficiary (within the meaning of section 106(g)) with respect to the employee'', and

(iii) by striking ''and their dependents'' both places it appears and inserting ''and such employees' dependents and eligible beneficiaries (within the meaning of section 106(g))''.

(D) Section 3401(a) of such Code is amended by striking ''or'' at the end of paragraph (22), by striking the period at the end of paragraph (23) and inserting ''; or'', and by inserting after paragraph (23) the following new paragraph:

''(24) for any payment made to or for the benefit of an employee or any eligible beneficiary (within the meaning of section 106(g)) if at the time of such payment it is reasonable to believe that the employee will be able to exclude such payment from income under section 106 or under section 105 by reference in section 105(b) to section 106(g).''.

(b) EXPANSION OF DEPENDENCY FOR PURPOSES OF DEDUCTION FOR HEALTH INSURANCE COSTS OF SELF-EMPLOYED INDIVIDUALS.—

(1) IN GENERAL.—Paragraph (1) of section 162(l) of the Internal Revenue Code of 1986 (relating to special rules for health insurance costs of self-employed individuals) is amended to read as follows:

''(1) ALLOWANCE OF DEDUCTION.—In the case of a taxpayer who is an employee within the meaning of section 401(c)(1), there shall be allowed as a deduction under this section an amount equal to the amount paid during the taxable year for insurance which constitutes medical care for—

''(A) the taxpayer,

''(B) the taxpayer's spouse,

''(C) the taxpayer's dependents,

''(D) any individual who—

''(i) satisfies the age requirements of section 152(c)(3)(A),

''(ii) bears a relationship to the taxpayer described in section 152(d)(2)(H), and

''(iii) meets the requirements of section 152(d)(1)(C), and

''(E) one individual who—

''(i) does not satisfy the age requirements of section 152(c)(3)(A),

''(ii) bears a relationship to the taxpayer described in section 152(d)(2)(H),

''(iii) meets the requirements of section 152(d)(1)(D), and

''(iv) is not the spouse of the taxpayer and does not bear any relationship to the taxpayer described in subparagraphs (A) through (G) of section 152(d)(2).''.

(2) CONFORMING AMENDMENT.—Subparagraph (B) of section 162(l)(2) of such Code is amended by inserting '', any dependent, or individual described in subparagraph (D) or (E) of paragraph (1) with respect to'' after ''spouse''.

(c) EXTENSION TO ELIGIBLE BENEFICIARIES OF SICK AND ACCIDENT BENEFITS PROVIDED TO MEMBERS OF A VOLUNTARY EMPLOYEES' BENEFICIARY ASSOCIATION AND THEIR DEPENDENTS.—Section 501(c)(9) of the Internal Revenue Code of 1986 (relating to list of exempt organizations) is amended by adding at the end the following new sentence: ''For purposes of providing for the payment of sick and accident benefits to members of such an association and their dependents, the term 'dependents' shall include any individual who is an eligible beneficiary

(within the meaning of section 106(g)), as determined under the terms of a medical benefit, health insurance, or other program under which members and their dependents are entitled to sick and accident benefits.''.

(d) FLEXIBLE SPENDING ARRANGEMENTS AND HEALTH REIMBURSEMENT ARRANGEMENTS.—The Secretary of Treasury shall issue guidance of general applicability providing that medical expenses that otherwise qualify—

(1) for reimbursement from a flexible spending arrangement under regulations in effect on the date of the enactment of this Act may be reimbursed from an employee's flexible spending arrangement, notwithstanding the fact that such expenses are attributable to any individual who is not the employee's spouse or dependent (within the meaning of section 105(b) of the Internal Revenue Code of 1986) but is an eligible beneficiary (within the meaning of section 106(g) of such Code) under the flexible spending arrangement with respect to the employee, and

(2) for reimbursement from a health reimbursement arrangement under regulations in effect on the date of the enactment of this Act may be reimbursed from an employee's health reimbursement arrange-

ment, notwithstanding the fact that such expenses are attributable to an individual who is not a spouse or dependent (within the meaning of section 105(b) of such Code) but is an eligible beneficiary (within the meaning of section 106(g) of such Code) under the health reimbursement arrangement with respect to the employee.

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

DIVISION B—MEDICARE AND MEDICAID IMPROVEMENTS

SEC. 1001. TABLE OF CONTENTS OF DIVISION.

The table of contents of this division is as follows:

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 I—IMPROVING HEALTH CARE VALUE

Subtitle A—Provisions Related to Medicare Part A

PART 1—MARKET BASKET UPDATES

SEC. 1101. SKILLED NURSING FACILITY PAYMENT UPDATE.

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

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

(2) by redesignating subclause (IV) as subclause (VI); and

(3) by inserting after subclause (III) the following new subclauses:

''(IV) for each of fiscal years 2004 through 2009, the rate computed for the previous fiscal year increased by the skilled nursing facility market basket percentage change for the fiscal year involved;

''(V) for fiscal year 2010, the rate computed for the previous fiscal year; and''.

(b) DELAYED EFFECTIVE DATE.—Section 1888(e)(4)(E)(ii)(V) of the Social Security Act, as inserted by subsection (a)(3), shall not apply to payment for days before January 1, 2010.

SEC. 1102. INPATIENT REHABILITATION FACILITY PAYMENT UPDATE.

(a) IN GENERAL.—Section 1886(j)(3)(C) of the Social Security Act (42 U.S.C. 1395ww(j)(3)(C)) is amended by striking ''and 2009'' and inserting ''through 2010''.

(b) DELAYED EFFECTIVE DATE.—The amendment made by subsection (a) shall not apply to payment units occurring before January 1, 2010.

SEC. 1103. INCORPORATING PRODUCTIVITY IMPROVEMENTS INTO MARKET BASKET UPDATES THAT DO NOT ALREADY INCORPORATE SUCH IMPROVEMENTS.

(a) INPATIENT ACUTE HOSPITALS.—Section 1886(b)(3)(B) of the Social Security Act (42 U.S.C. 1395ww(b)(3)(B)) is amended—

(1) in clause (iii)—

(A) by striking ''(iii) For purposes of this subparagraph,'' and inserting ''(iii)(I) For purposes of this subparagraph, subject to the productivity adjustment described in subclause (II),''; and

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

''(II) The productivity adjustment described in this subclause, with respect to an increase or change for a fiscal year or year or cost reporting period, or other annual period, is a productivity offset in the form of a reduction in such increase or change equal to the percentage change in the 10-year moving average of annual economy-wide private nonfarm business multi-factor productivity (as recently published in final form before the promulgation or publication of such increase for the year or period involved). Except as otherwise provided, any reference to the increase described in this clause shall be a reference to the percentage increase described in subclause (I) minus the percentage change under this subclause.'';

(2) in the first sentence of clause (viii)(I), by inserting ''(but not below zero)'' after ''shall be reduced''; and

(3) in the first sentence of clause (ix)(I)—

(A) by inserting ''(determined without regard to clause (iii)(II))'' after ''clause (i)'' the second time it appears; and

(B) by inserting ''(but not below zero)'' after ''reduced''.

(b) SKILLED NURSING FACILITIES.—Section 1888(e)(5)(B) of such Act (42 U.S.C. 1395yy(e)(5)(B)) is amended by inserting ''subject to the productivity adjustment described in section 1886(b)(3)(B)(iii)(II)'' after ''as calculated by the Secretary''.

(c) LONG TERM CARE HOSPITALS.—Section 1886(m) of the Social Security Act (42 U.S.C. 1395ww(m)) is amended by adding at the end the following new paragraph:

''(3) PRODUCTIVITY ADJUSTMENT.—In implementing the system described in paragraph (1) for discharges occurring on or after January 1, 2010, during the rate year ending in 2010 or any subsequent rate year for a hospital, to the extent that an annual percentage increase factor applies to a standard Federal rate for such discharges for the hospital, such factor shall be subject to the productivity adjustment described in subsection (b)(3)(B)(iii)(II).''.

(d) INPATIENT REHABILITATION FACILITIES.—The second sentence of section 1886(j)(3)(C) of the Social Security Act (42 U.S.C. 1395ww(j)(3)(C)) is amended by inserting ''(subject to the productivity adjustment described in subsection (b)(3)(B)(iii)(II))'' after ''appropriate percentage increase''.

(e) PSYCHIATRIC HOSPITALS.—Section 1886 of the Social Security Act (42 U.S.C. 1395ww) is amended by adding at the end the following new subsection:

"(o) PROSPECTIVE PAYMENT FOR PSYCHIATRIC HOSPITALS.—

"(1) REFERENCE TO ESTABLISHMENT AND IMPLEMENTATION OF SYSTEM.—For provisions related to the establishment and implementation of a prospective payment system for payments under this title for inpatient hospital services furnished by psychiatric hospitals (as described in clause (i) of subsection (d)(1)(B) and psychiatric units (as described in the matter following clause (v) of such subsection), see section 124 of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999.

"(2) PRODUCTIVITY ADJUSTMENT.—In implementing the system described in paragraph (1) for days occurring during the rate year ending in 2011 or any subsequent rate year for a psychiatric hospital or unit described in such paragraph, to the extent that an annual percentage increase factor applies to a base rate for such days for the hospital or unit, respectively, such factor shall be subject to

the productivity adjustment described in subsection (b)(3)(B)(iii)(II).''.

(f) HOSPICE CARE.—Subclause (VII) of section 1814(i)(1)(C)(ii) of the Social Security Act (42 U.S.C. 1395f(i)(1)(C)(ii)) is amended by inserting after ''the market basket percentage increase'' the following: ''(which is subject to the productivity adjustment described in section 1886(b)(3)(B)(iii)(II))''.

(g) EFFECTIVE DATES.—

(1) IPPS.—The amendments made by subsection (a) shall apply to annual increases effected for fiscal years beginning with fiscal year 2010, but only with respect to discharges occurring on or after January 1, 2010.

(2) SNF AND IRF.—The amendments made by subsections (b) and (d) shall apply to annual increases effected for fiscal years beginning with fiscal year 2011.

(3) HOSPICE CARE.—The amendment made by subsection (f) shall apply to annual increases effected for fiscal years beginning with fiscal year 2010, but only with respect to days of care occurring on or after January 1, 2010.

PART 2—OTHER MEDICARE PART A PROVISIONS

SEC. 1111. PAYMENTS TO SKILLED NURSING FACILITIES.

(a) CHANGE IN RECALIBRATION FACTOR.—

(1) ANALYSIS.—The Secretary of Health and Human Services shall conduct, using calendar year 2006 claims data, an initial analysis comparing total payments under title XVIII of the Social Security Act for skilled nursing facility services under the RUG–53 and under the RUG–44 classification systems.

(2) ADJUSTMENT IN RECALIBRATION FACTOR.—Based on the initial analysis under paragraph (1), the Secretary shall adjust the case mix indexes under section 1888(e)(4)(G)(i) of the Social Security Act (42 U.S.C. 1395yy(e)(4)(G)(i)) for fiscal year 2010 by the appropriate recalibration factor as proposed in the proposed rule for Medicare skilled nursing facilities issued by such Secretary on May 12, 2009 (74 Federal Register 22214 et seq.).

(b) CHANGE IN PAYMENT FOR NONTHERAPY ANCILLARY (NTA) SERVICES AND THERAPY SERVICES.—

(1) CHANGES UNDER CURRENT SNF CLASSIFICATION SYSTEM.—

(A) IN GENERAL.—Subject to subparagraph (B), the Secretary of Health and Human Services shall, under the system for payment of

skilled nursing facility services under section 1888(e) of the Social Security Act (42 U.S.C. 1395yy(e)), increase payment by 10 percent for non-therapy ancillary services (as specified by the Secretary in the notice issued on November 27, 1998 (63 Federal Register 65561 et seq.)) and shall decrease payment for the therapy case mix component of such rates by 5.5 percent.

(B) EFFECTIVE DATE.—The changes in payment described in subparagraph (A) shall apply for days on or after January 1, 2010, and until the Secretary implements an alternative case mix classification system for payment of skilled nursing facility services under section 1888(e) of the Social Security Act (42 U.S.C. 1395yy(e)).

(C) IMPLEMENTATION.—Notwithstanding any other provision of law, the Secretary may implement by program instruction or otherwise the provisions of this paragraph.

(2) CHANGES UNDER A FUTURE SNF CASE MIX CLASSIFICATION SYSTEM.—

(A) ANALYSIS.—

(i) IN GENERAL.—The Secretary of Health and Human Services shall analyze

payments for non-therapy ancillary services under a future skilled nursing facility classification system to ensure the accuracy of payment for non-therapy ancillary services. Such analysis shall consider use of appropriate predictors which may include age, physical and mental status, ability to perform activities of daily living, prior nursing home stay, diagnoses, broad RUG category, and a proxy for length of stay.

(ii) APPLICATION.—Such analysis shall be conducted in a manner such that the future skilled nursing facility classification system is implemented to apply to services furnished during a fiscal year beginning with fiscal year 2011.

(B) CONSULTATION.—In conducting the analysis under subparagraph (A), the Secretary shall consult with interested parties, including the Medicare Payment Advisory Commission and other interested stakeholders, to identify appropriate predictors of nontherapy ancillary costs.

(C) RULEMAKING.—The Secretary shall include the result of the analysis under sub-

paragraph (A) in the fiscal year 2011 rule-making cycle for purposes of implementation beginning for such fiscal year.

(D) IMPLEMENTATION.—Subject to subparagraph (E) and consistent with subparagraph (A)(ii), the Secretary shall implement changes to payments for non-therapy ancillary services (which shall include a separate rate component for non-therapy ancillary services and may include use of a model that predicts payment amounts applicable for non-therapy ancillary services) under such future skilled nursing facility services classification system as the Secretary determines appropriate based on the analysis conducted pursuant to subparagraph (A).

(E) BUDGET NEUTRALITY.—The Secretary shall implement changes described in subparagraph (D) in a manner such that the estimated expenditures under such future skilled nursing facility services classification system for a fiscal year beginning with fiscal year 2011 with such changes would be equal to the estimated expenditures that would otherwise occur under title XVIII of the Social Security Act under

such future skilled nursing facility services classification system for such year without such changes.

(c) OUTLIER POLICY FOR NTA AND THERAPY.—Section 1888(e) of the Social Security Act (42 U.S.C. 1395yy(e)) is amended by adding at the end the following new paragraph:

''(13) OUTLIERS FOR NTA AND THERAPY.—

''(A) IN GENERAL.—With respect to outliers because of unusual variations in the type or amount of medically necessary care, beginning with October 1, 2010, the Secretary—

''(i) shall provide for an addition or adjustment to the payment amount otherwise made under this section with respect to non-therapy ancillary services in the case of such outliers; and

''(ii) may provide for such an addition or adjustment to the payment amount otherwise made under this section with respect to therapy services in the case of such outliers.

''(B) OUTLIERS BASED ON AGGREGATE COSTS.—Outlier adjustments or additional payments described in subparagraph (A) shall be

based on aggregate costs during a stay in a skilled nursing facility and not on the number of days in such stay.

''(C) BUDGET NEUTRALITY.—The Secretary shall reduce estimated payments that would otherwise be made under the prospective payment system under this subsection with respect to a fiscal year by 2 percent. The total amount of the additional payments or payment adjustments for outliers made under this paragraph with respect to a fiscal year may not exceed 2 percent of the total payments projected or estimated to be made based on the prospective payment system under this subsection for the fiscal year.''.

(d) CONFORMING AMENDMENTS.—Section 1888(e)(8) of such Act (42 U.S.C. 1395yy(e)(8)) is amended—

(1) in subparagraph (A)—

(A) by striking ''and'' before ''adjustments''; and

(B) by inserting '', and adjustment under section 1111(b) of the Affordable Health Care for America Act'' before the semicolon at the end;

(2) in subparagraph (B), by striking ''and'';

(3) in subparagraph (C), by striking the period and inserting ''; and''; and

(4) by adding at the end the following new subparagraph:

''(D) the establishment of outliers under paragraph (13).''.

SEC. 1112. MEDICARE DSH REPORT AND PAYMENT ADJUSTMENTS IN RESPONSE TO COVERAGE EXPANSION.

(a) DSH REPORT.—

(1) IN GENERAL.—Not later than January 1, 2016, the Secretary of Health and Human Services shall submit to Congress a report on Medicare DSH taking into account the impact of the health care reforms carried out under division A in reducing the number of uninsured individuals. The report shall include recommendations relating to the following:

(A) The appropriate amount, targeting, and distribution of Medicare DSH to compensate for higher Medicare costs associated with serving low-income beneficiaries (taking into account variations in the empirical justification for Medicare DSH attributable to hospital characteristics, including bed size), con-

sistent with the original intent of Medicare DSH.

(B) The appropriate amount, targeting, and distribution of Medicare DSH to hospitals given their continued uncompensated care costs, to the extent such costs remain.

(2) COORDINATION WITH MEDICAID DSH REPORT.—The Secretary shall coordinate the report under this subsection with the report on Medicaid DSH under section 1704(a).

(b) PAYMENT ADJUSTMENTS IN RESPONSE TO COVERAGE EXPANSION.—

(1) IN GENERAL.—If there is a significant decrease in the national rate of uninsurance as a result of this Act (as determined under paragraph (2)(A)), then the Secretary of Health and Human Services shall, beginning in fiscal year 2017, implement the following adjustments to Medicare DSH:

(A) In lieu of the amount of Medicare DSH payment that would otherwise be made under section 1886(d)(5)(F) of the Social Security Act, the amount of Medicare DSH payment shall be an amount based on the recommendations of the report under subsection (a)(1)(A) and shall take into account variations in the

empirical justification for Medicare DSH attributable to hospital characteristics, including bed size.

(B) Subject to paragraph (3), make an additional payment to a hospital by an amount that is estimated based on the amount of uncompensated care provided by the hospital based on criteria for uncompensated care as determined by the Secretary, which shall exclude bad debt.

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

(A) IN GENERAL.—There is a ''significant decrease in the national rate of uninsurance as a result of this Act'' if there is a decrease in the national rate of uninsurance (as defined in subparagraph (B)) from 2012 to 2014 that exceeds 8 percentage points.

(B) NATIONAL RATE OF UNINSURANCE DEFINED.—The term ''national rate of uninsurance'' means, for a year, such rate for the under-65 population for the year as determined and published by the Bureau of the Cen-

sus in its Current Population Survey in or about September of the succeeding year.

(3) UNCOMPENSATED CARE INCREASE.—

(A) COMPUTATION OF DSH SAVINGS.—For each fiscal year (beginning with fiscal year 2017), the Secretary shall estimate the aggregate reduction in the amount of Medicare DSH payment that would be expected to result from the adjustment under paragraph (1)(A).

(B) STRUCTURE OF PAYMENT INCREASE.—The Secretary shall compute the additional payment to a hospital as described in paragraph (1)(B) for a fiscal year in accordance with a formula established by the Secretary that provides that—

(i) the estimated aggregate amount of such increase for the fiscal year does not exceed 50 percent of the aggregate reduction in Medicare DSH estimated by the Secretary for such fiscal year; and

(ii) hospitals with higher levels of uncompensated care receive a greater increase.

(c) MEDICARE DSH.—In this section, the term ''Medicare DSH'' means adjustments in payments under

section 1886(d)(5)(F) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(F)) for inpatient hospital services furnished by disproportionate share hospitals.

SEC. 1113. EXTENSION OF HOSPICE REGULATION MORATORIUM.

Section 4301(a) of division B of the American Recovery and Reinvestment Act of 2009 (Public Law 111–5) is amended—

(1) by striking ''October 1, 2009'' and inserting ''October 1, 2010''; and

(2) by striking ''for fiscal year 2009'' and inserting ''for fiscal years 2009 and 2010''.

SEC. 1114. PERMITTING PHYSICIAN ASSISTANTS TO ORDER POST-HOSPITAL EXTENDED CARE SERVICES AND TO PROVIDE FOR RECOGNITION OF ATTENDING PHYSICIAN ASSISTANTS AS ATTENDING PHYSICIANS TO SERVE HOSPICE PATIENTS.

(a) ORDERING POST-HOSPITAL EXTENDED CARE SERVICES.—Section 1814(a) of the Social Security Act (42 U.S.C. 1395f(a)) is amended—

(1) in paragraph (2) in the matter preceding subparagraph (A), is amended by striking ''nurse practitioner or clinical nurse specialist'' and insert-

ing ''nurse practitioner, a clinical nurse specialist, or a physician assistant''.

(2) in the second sentence, by striking ''or clinical nurse specialist'' and inserting ''clinical nurse specialist, or physician assistant''.

(b) RECOGNITION OF ATTENDING PHYSICIAN ASSISTANTS AS ATTENDING PHYSICIANS TO SERVE HOSPICE PATIENTS.—

(1) IN GENERAL.—Section 1861(dd)(3)(B) of such Act (42 U.S.C. 1395x(dd)(3)(B)) is amended—

(A) by striking ''or nurse'' and inserting '', the nurse''; and

(B) by inserting ''or the physician assistant (as defined in such subsection),'' after ''subsection (aa)(5)),''.

(2) CONFORMING AMENDMENT.—Section 1814(a)(7)(A)(i)(I) of such Act (42 U.S.C. 1395f(a)(7)(A)(i)(I)) is amended by inserting ''or a physician assistant'' after ''a nurse practitioner''.

(3) CONSTRUCTION.—Nothing in the amendments made by this subsection shall be construed as changing the requirements of section 1842(b)(6)(C) of the Social Security Act (42 U.S.C. 1395u(b)(6)(C)) with respect to payment for serv-

ices of physician assistants under part B of title XVIII of such Act.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to items and services furnished on or after January 1, 2010.

Subtitle B—Provisions Related to Part B

PART 1—PHYSICIANS' SERVICES

SEC. 1121. RESOURCE-BASED FEEDBACK PROGRAM FOR PHYSICIANS IN MEDICARE.

Section 1848(n) of the Social Security Act (42 U.S.C. 1395w–4(n)) is amended by adding at the end the following new paragraph:

''(9) FEEDBACK IMPLEMENTATION PLAN.—

''(A) TIMELINE FOR FEEDBACK PROGRAM.—

''(i) EVALUATION.—During 2011 the Secretary shall conduct the evaluation specified in subparagraph (E)(i).

''(ii) EXPANSION.—The Secretary shall expand the Program under this subsection as specified in subparagraph (E)(ii).

''(B) ESTABLISHMENT OF NATURE OF REPORTS.—

''(i) IN GENERAL.—The Secretary shall develop and specify the nature of the reports that will be disseminated under this subsection, based on results and findings from the Program under this subsection as in existence before the date of the enactment of this paragraph. Such reports may be based on a per capita basis, an episode basis that combines separate but clinically related physicians' services and other items and services furnished or ordered by a physician into an episode of care, as appropriate, or both.

''(ii) TIMELINE FOR DEVELOPMENT.—The nature of the reports described in clause (i) shall be developed by not later than January 1, 2012.

''(iii) PUBLIC AVAILABILITY.—The Secretary shall make the details of the nature of the reports developed under clause (i) available to the public.

''(C) ANALYSIS OF DATA.—The Secretary shall, for purposes of preparing reports under this subsection, establish methodologies as appropriate such as to—

''(i) attribute items and services, in whole or in part, to physicians;

''(ii) identify appropriate physicians for purposes of comparison under subparagraph (B)(i); and

''(iii) aggregate items and services attributed to a physician under clause (i) into a composite measure per individual.

''(D) FEEDBACK PROGRAM.—The Secretary shall engage in efforts to disseminate reports under this subsection. In disseminating such reports, the Secretary shall consider the following:

''(i) Direct meetings between contracted physicians, facilitated by the Secretary, to discuss the contents of reports under this subsection, including any reasons for divergence from local or national averages.

''(ii) Contract with local, non-profit entities engaged in quality improvement efforts at the community level. Such entities shall use the reports under this subsection, or such equivalent tool as specified by the Secretary. Any exchange of data under this

paragraph shall be protected by appropriate privacy safeguards.

''(iii) Mailings or other methods of communication that facilitate large-scale dissemination.

''(iv) Other methods specified by the Secretary.

''(E) EVALUATION AND EXPANSION.—

''(i) EVALUATION.—The Secretary shall evaluate the methods specified in subparagraph (D) with regard to their efficacy in changing practice patterns to improve quality and decrease costs.

''(ii) EXPANSION.—Taking into account the cost of each method specified in subparagraph (D), the Secretary shall develop a plan to disseminate reports under this subsection in a significant manner in the regions and cities of the country with the highest utilization of services under this title. To the extent practicable, reports under this subsection shall be disseminated to increasing numbers of physicians each year, such that during 2014 and subsequent years, reports are disseminated at

least to physicians with utilization rates among the highest 5 percent of the nation, subject the authority to focus under paragraph (4).

''(F) ADMINISTRATION.—

''(i) Chapter 35 of title 44, United States Code shall not apply to this paragraph.

''(ii) Notwithstanding any other provision of law, the Secretary may implement the provisions of this paragraph by program instruction or otherwise.''.

SEC. 1122. MISVALUED CODES UNDER THE PHYSICIAN FEE SCHEDULE.

(a) IN GENERAL.—Section 1848(c)(2) of the Social Security Act (42 U.S.C. 1395w-4(c)(2)) is amended by adding at the end the following new subparagraphs:

''(K) POTENTIALLY MISVALUED CODES.—

''(i) IN GENERAL.—The Secretary shall—

''(I) periodically identify services as being potentially misvalued using criteria specified in clause (ii); and

''(II) review and make appropriate adjustments to the relative val-

ues established under this paragraph for services identified as being potentially misvalued under subclause (I).

''(ii) IDENTIFICATION OF POTENTIALLY MISVALUED CODES.—For purposes of identifying potentially misvalued services pursuant to clause (i)(I), the Secretary shall examine (as the Secretary determines to be appropriate) codes (and families of codes as appropriate) for which there has been the fastest growth; codes (and families of codes as appropriate) that have experienced substantial changes in practice expenses; codes for new technologies or services within an appropriate period (such as three years) after the relative values are initially established for such codes; multiple codes that are frequently billed in conjunction with furnishing a single service; codes with low relative values, particularly those that are often billed multiple times for a single treatment; codes which have not been subject to review since the implementation of the RBRVS (the so-called 'Harvard-valued codes'); and such

other codes determined to be appropriate by the Secretary.

''(iii) REVIEW AND ADJUSTMENTS.—

''(I) The Secretary may use existing processes to receive recommendations on the review and appropriate adjustment of potentially misvalued services described clause (i)(II).

''(II) The Secretary may conduct surveys, other data collection activities, studies, or other analyses as the Secretary determines to be appropriate to facilitate the review and appropriate adjustment described in clause (i)(II).

''(III) The Secretary may use analytic contractors to identify and analyze services identified under clause (i)(I), conduct surveys or collect data, and make recommendations on the review and appropriate adjustment of services described in clause (i)(II).

''(IV) The Secretary may coordinate the review and appropriate adjustment described in clause (i)(II) with the periodic review described in subparagraph (B).

''(V) As part of the review and adjustment described in clause (i)(II), including with respect to codes with low relative values described in clause (ii), the Secretary may make appropriate coding revisions (including using existing processes for consideration of coding changes) which may include consolidation of individual services into bundled codes for payment under the fee schedule under subsection (b).

''(VI) The provisions of subparagraph (B)(ii)(II) shall apply to adjustments to relative value units made pursuant to this subparagraph in the same manner as such provisions apply to adjustments under subparagraph (B)(ii)(II).

"(L) VALIDATING RELATIVE VALUE UNITS.—

"(i) IN GENERAL.—The Secretary shall establish a process to validate relative value units under the fee schedule under subsection (b).

"(ii) COMPONENTS AND ELEMENTS OF WORK.—The process described in clause (i) may include validation of work elements (such as time, mental effort and professional judgment, technical skill and physical effort, and stress due to risk) involved with furnishing a service and may include validation of the pre, post, and intra-service components of work.

"(iii) SCOPE OF CODES.—The validation of work relative value units shall include a sampling of codes for services that is the same as the codes listed under subparagraph (K)(ii)

"(iv) METHODS.—The Secretary may conduct the validation under this subparagraph using methods described in subclauses (I) through (V) of subparagraph

(K)(iii) as the Secretary determines to be appropriate.

''(v) ADJUSTMENTS.—The Secretary shall make appropriate adjustments to the work relative value units under the fee schedule under subsection (b). The provisions of subparagraph (B)(ii)(II) shall apply to adjustments to relative value units made pursuant to this subparagraph in the same manner as such provisions apply to adjustments under subparagraph (B)(ii)(II).''.

(b) IMPLEMENTATION.—

(1) FUNDING.—For purposes of carrying out the provisions of subparagraphs (K) and (L) of 1848(c)(2) of the Social Security Act, as added by subsection (a), in addition to funds otherwise available, out of any funds in the Treasury not otherwise appropriated, there are appropriated to the Secretary of Health and Human Services for the Center for Medicare & Medicaid Services Program Management Account $20,000,000 for fiscal year 2010 and each subsequent fiscal year. Amounts appropriated under this paragraph for a fiscal year shall be available until expended.

(2) ADMINISTRATION.—

(A) Chapter 35 of title 44, United States Code and the provisions of the Federal Advisory Committee Act (5 U.S.C. App.) shall not apply to this section or the amendment made by this section.

(B) Notwithstanding any other provision of law, the Secretary may implement subparagraphs (K) and (L) of 1848(c)(2) of the Social Security Act, as added by subsection (a), by program instruction or otherwise.

(C) Section 4505(d) of the Balanced Budget Act of 1997 is repealed.

(D) Except for provisions related to confidentiality of information, the provisions of the Federal Acquisition Regulation shall not apply to this section or the amendment made by this section.

(3) FOCUSING CMS RESOURCES ON POTENTIALLY OVERVALUED CODES.—Section 1868(a) of the Social Security Act (42 1395ee(a)) is repealed.

SEC. 1123. PAYMENTS FOR EFFICIENT AREAS.

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

''(x) INCENTIVE PAYMENTS FOR EFFICIENT AREAS.—

''(1) IN GENERAL.—In the case of services furnished under the physician fee schedule under section 1848 on or after January 1, 2011, and before January 1, 2013, by a supplier that is paid under such fee schedule in an efficient area (as identified under paragraph (2)), in addition to the amount of payment that would otherwise be made for such services under this part, there also shall be paid (on a monthly or quarterly basis) an amount equal to 5 percent of the payment amount for the services under this part.

''(2) IDENTIFICATION OF EFFICIENT AREAS.—

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

''(B) IDENTIFICATION OF COUNTIES WHERE SERVICE IS FURNISHED..—For purposes of paying the additional amount specified in paragraph (1), if the Secretary uses the 5-digit postal ZIP Code where the service is furnished, the dominant county of the postal ZIP Code (as determined by the United States Postal Service, or otherwise) shall be used to determine whether the postal ZIP Code is in a county described in subparagraph (A).

''(C) LIMITATION ON REVIEW.—There shall be no administrative or judicial review under section 1869, 1878, or otherwise, respecting—

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

''(ii) the assignment of a postal ZIP Code to a county or other area under subparagraph (B).

''(D) PUBLICATION OF LIST OF COUNTIES; POSTING ON WEBSITE.—With respect to a year for which a county or area is identified under this paragraph, the Secretary shall identify such counties or areas as part of the proposed and final rule to implement the physician fee

schedule under section 1848 for the applicable year. The Secretary shall post the list of counties identified under this paragraph on the Internet website of the Centers for Medicare & Medicaid Services.''.

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

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

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

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

(1) in subparagraph (E), by striking ''There shall be'' and inserting ''Except as provided in subparagraph (I), there shall be''; and

(2) by adding at the end the following new subparagraph:

''(I) INFORMAL APPEALS PROCESS.—By not later than January 1, 2011, the Secretary shall establish and have in place an informal process for eligible professionals to seek a re-

view of the determination that an eligible professional did not satisfactorily submit data on quality measures under this subsection.''.

(c) INTEGRATION OF PHYSICIAN QUALITY REPORTING AND EHR REPORTING.—Section 1848(m) of such Act is amended by adding at the end the following new paragraph:

''(7) INTEGRATION OF PHYSICIAN QUALITY REPORTING AND EHR REPORTING.—Not later than January 1, 2012, the Secretary shall develop a plan to integrate clinical reporting on quality measures under this subsection with reporting requirements under subsection (o) relating to the meaningful use of electronic health records. Such integration shall consist of the following:

''(A) The development of measures, the reporting of which would both demonstrate—

''(i) meaningful use of an electronic health record for purposes of subsection (o); and

''(ii) clinical quality of care furnished to an individual.

''(B) The collection of health data to identify deficiencies in the quality and coordination

of care for individuals eligible for benefits under this part.

''(C) Such other activities as specified by the Secretary.''.

(d) EXTENSION OF INCENTIVE PAYMENTS.—Section 1848(m)(1) of such Act (42 U.S.C. 1395w–4(m)(1)) is amended—

(1) in subparagraph (A), by striking ''2010'' and inserting ''2012''; and

(2) in subparagraph (B)(ii), by striking ''2009 and 2010'' and inserting ''for each of the years 2009 through 2012''.

SEC. 1125. ADJUSTMENT TO MEDICARE PAYMENT LOCALITIES.

(a) IN GENERAL.—Section 1848(e) of the Social Security Act (42 U.S.C.1395w–4(e)) is amended by adding at the end the following new paragraph:

''(6) TRANSITION TO USE OF MSAS AS FEE SCHEDULE AREAS IN CALIFORNIA.—

''(A) IN GENERAL.—

''(i) REVISION.—Subject to clause (ii) and notwithstanding the previous provisions of this subsection, for services furnished on or after January 1, 2011, the Secretary shall revise the fee schedule

areas used for payment under this section applicable to the State of California using the Metropolitan Statistical Area (MSA) iterative Geographic Adjustment Factor methodology as follows:

''(I) The Secretary shall configure the physician fee schedule areas using the Metropolitan Statistical Areas (each in this paragraph referred to as an 'MSA'), as defined by the Director of the Office of Management and Budget and published in the Federal Register, using the most recent available decennial population data as of the date of the enactment of the Affordable Health Care for America Act, as the basis for the fee schedule areas.

''(II) For purposes of this clause, the Secretary shall treat all areas not included in an MSA as a single rest of the State MSA.

''(III) The Secretary shall list all MSAs within the State by Geographic Adjustment Factor described in para-

graph (2) (in this paragraph referred to as a 'GAF') in descending order.

''(IV) In the first iteration, the Secretary shall compare the GAF of the highest cost MSA in the State to the weighted-average GAF of all the remaining MSAs in the State (including the rest of State MSA described in subclause (II)). If the ratio of the GAF of the highest cost MSA to the weighted-average of the GAF of remaining lower cost MSAs is 1.05 or greater, the highest cost MSA shall be a separate fee schedule area.

''(V) In the next iteration, the Secretary shall compare the GAF of the MSA with the second-highest GAF to the weighted-average GAF of the all the remaining MSAs (excluding MSAs that become separate fee schedule areas). If the ratio of the second-highest MSA's GAF to the weighted-average of the remaining lower cost MSAs is 1.05 or greater, the second-highest MSA shall be a separate fee

schedule area. ''(VI) The iterative process shall continue until the ratio of the GAF of the MSA with highest remaining GAF to the weighted-average of the remaining MSAs with lower GAFS is less than 1.05, and the remaining group of MSAs with lower GAFS shall be treated as a single fee schedule area.

''(VI) For purposes of the iterative process described in this clause, if two MSAs have identical GAFs, they shall be combined.

''(ii) TRANSITION.—For services furnished on or after January 1, 2011, and before January 1, 2016, in the State of California, after calculating the work, practice expense, and malpractice geographic indices that would otherwise be determined under clauses (i), (ii), and (iii) of paragraph (1)(A) for a fee schedule area determined under clause (i), if the index for a county within a fee schedule area is less than the index in effect for such county on December 31, 2010, the Secretary shall in-

stead apply the index in effect for such county on such date.

''(B) SUBSEQUENT REVISIONS.—After the transition described in subparagraph (A)(ii), not less than every 3 years the Secretary shall review and update the fee schedule areas using the methodology described in subparagraph (A)(i) and any updated MSAs as defined by the Director of the Office of Management and Budget and published in the Federal Register. The Secretary shall review and make any changes pursuant to such reviews concurrent with the application of the periodic review of the adjustment factors required under paragraph (1)(C) for California.

''(C) REFERENCES TO FEE SCHEDULE AREAS.—Effective for services furnished on or after January 1, 2011, for the State of California, any reference in this section to a fee schedule area shall be deemed a reference to an MSA in the State (including the single rest of state MSA described in subparagraph (A)(i)(II)).''.

(b) CONFORMING AMENDMENT TO DEFINITION OF FEE SCHEDULE AREA.—Section 1848(j)(2) of the Social

Security Act (42 U.S.C. 1395w(j)(2)) is amended by striking ''The term'' and inserting ''Except as provided in subsection (e)(6)(C), the term''.

PART 2—MARKET BASKET UPDATES

SEC. 1131. INCORPORATING PRODUCTIVITY IMPROVEMENTS INTO MARKET BASKET UPDATES THAT DO NOT ALREADY INCORPORATE SUCH IMPROVEMENTS.

(a) OUTPATIENT HOSPITALS.—

(1) IN GENERAL.—Section 1833(t)(3)(C)(iv) of the Social Security Act (42 U.S.C. 1395l(t)(3)(C)(iv)) is amended——

(A) in the first sentence—

(i) by inserting ''(which is subject to the productivity adjustment described in subclause (II) of such section)'' after ''1886(b)(3)(B)(iii)''; and

(ii) by inserting ''(but not below 0)'' after ''reduced''; and

(B) in the second sentence, by inserting ''and which is subject, beginning with 2010, to the productivity adjustment described in section 1886(b)(3)(B)(iii)(II)''.

(2) EFFECTIVE DATE.—The amendments made by this subsection shall apply to increase factors for services furnished in years beginning with 2010.

(b) AMBULANCE SERVICES.—Section 1834(l)(3)(B) of such Act (42 U.S.C. 1395m(l)(3)(B))) is amended by inserting before the period at the end the following: ''and, in the case of years beginning with 2010, subject to the productivity adjustment described in section 1886(b)(3)(B)(iii)(II)''.

(c) AMBULATORY SURGICAL CENTER SERVICES.—Section 1833(i)(2)(D) of such Act (42 U.S.C. 1395l(i)(2)(D)) is amended—

(1) by redesignating clause (v) as clause (vi); and

(2) by inserting after clause (iv) the following new clause:

''(v) In implementing the system described in clause (i), for services furnished during 2010 or any subsequent year, to the extent that an annual percentage change factor applies, such factor shall be subject to the productivity adjustment described in section 1886(b)(3)(B)(iii)(II).''.

(d) LABORATORY SERVICES.—Section 1833(h)(2)(A) of such Act (42 U.S.C. 1395l(h)(2)(A)) is amended—

(1) in clause (i), by striking ''for each of the years 2009 through 2013'' and inserting ''for 2009''; and

(2) clause (ii)—

(A) by striking ''and'' at the end of subclause (III);

(B) by striking the period at the end of subclause (IV) and inserting ''; and''; and

(C) by adding at the end the following new subclause:

''(V) the annual adjustment in the fee schedules determined under clause (i) for years beginning with 2010 shall be subject to the productivity adjustment described in section 1886(b)(3)(B)(iii)(II).''.

(e) CERTAIN DURABLE MEDICAL EQUIPMENT.—Section 1834(a)(14) of such Act (42 U.S.C. 1395m(a)(14)) is amended—

(1) in subparagraph (K), by inserting before the semicolon at the end the following: '', subject to the productivity adjustment described in section 1886(b)(3)(B)(iii)(II)'';

(2) in subparagraph (L)(i), by inserting after ''June 2013,'' the following: ''subject to the productivity adjustment described in section 1886(b)(3)(B)(iii)(II),'';

(3) in subparagraph (L)(ii), by inserting after ''June 2013'' the following: '', subject to the productivity adjustment described in section 1886(b)(3)(B)(iii)(II)''; and

(4) in subparagraph (M), by inserting before the period at the end the following: '', subject to the productivity adjustment described in section 1886(b)(3)(B)(iii)(II)''.

PART 3—OTHER PROVISIONS

SEC. 1141. RENTAL AND PURCHASE OF POWER-DRIVEN WHEELCHAIRS.

(a) IN GENERAL.—Section 1834(a)(7)(A)(iii) of the Social Security Act (42 U.S.C. 1395m(a)(7)(A)(iii)) is amended—

(1) in the heading, by inserting ''CERTAIN COMPLEX REHABILITATIVE'' after ''OPTION FOR''; and

(2) by striking ''power-driven wheelchair'' and inserting ''complex rehabilitative power-driven wheelchair recognized by the Secretary as classified within group 3 or higher''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall take effect on January 1, 2011, and shall apply to power-driven wheelchairs furnished on or after such date. Such amendments shall not apply to contracts entered into under section 1847 of the Social Secu-

rity Act (42 U.S.C. 1395w–3) pursuant to a bid submitted under such section before October 1, 2010, under subsection (a)(1)(B)(i)(I) of such section.

SEC. 1141A. ELECTION TO TAKE OWNERSHIP, OR TO DECLINE OWNERSHIP, OF A CERTAIN ITEM OF COMPLEX DURABLE MEDICAL EQUIPMENT AFTER THE 13-MONTH CAPPED RENTAL PERIOD ENDS.

(a) IN GENERAL.—Section 1834(a)(7)(A) of the Social Security Act (42 U.S.C. 1395m(a)(7)(A)) is amended—

(1) in clause (ii)—

(A) by striking ''RENTAL.—On'' and inserting ''RENTAL.—

''(I) IN GENERAL.—Except as provided in subclause (II), on''; and

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

''(II) OPTION TO ACCEPT OR REJECT TRANSFER OF TITLE TO GROUP 3 SUPPORT SURFACE.—

''(aa) IN GENERAL.—During the 10th continuous month during which payment is made for the rental of a Group 3 Support

Surface under clause (i), the supplier of such item shall offer the individual the option to accept or reject transfer of title to a Group 3 Support Surface after the 13th continuous month during which payment is made for the rental of the Group 3 Support Surface under clause (i). Such title shall be transferred to the individual only if the individual notifies the supplier not later than 1 month after the supplier makes such offer that the individual agrees to accept transfer of the title to the Group 3 Support Surface. Unless the individual accepts transfer of title to the Group 3 Support Surface in the manner set forth in this subclause, the individual shall be deemed to have rejected transfer of title. If the individual agrees to accept the transfer of the title to the Group 3 Support Surface, the supplier shall trans-

fer such title to the individual on the first day that begins after the 13th continuous month during which payment is made for the rental of the Group 3 Support Surface under clause (i).

''(bb) SPECIAL RULE.—If, on the effective date of this subclause, an individual's rental period for a Group 3 Support Surface has exceeded 10 continuous months, but the first day that begins after the 13th continuous month during which payment is made for the rental under clause (i) has not been reached, the supplier shall, within 1 month following such effective date, offer the individual the option to accept or reject transfer of title to a Group 3 Support Surface. Such title shall be transferred to the individual only if the individual notifies the supplier not later than 1 month after the supplier

makes such offer that the individual agrees to accept transfer of title to the Group 3 Support Surface. Unless the individual accepts transfer of title to the Group 3 Support Surface in the manner set forth in this subclause, the individual shall be deemed to have rejected transfer of title. If the individual agrees to accept the transfer of the title to the Group 3 Support Surface, the supplier shall transfer such title to the individual on the first day that begins after the 13th continuous month during which payment is made for the rental of the Group 3 Support Surface under clause (i) unless that day has passed, in which case the supplier shall transfer such title to the individual not later than 1 month after notification that the individual accepts transfer of title.

''(cc) TREATMENT OF SUBSEQUENT RESUPPLY WITHIN PERIOD OF REASONABLE USEFUL LIFETIME OF GROUP 3 SUPPORT SURFACE IN CASE OF NEED.—If an individual rejects transfer of title to a Group 3 Support Surface under this subclause and the individual requires such Support Surface at any subsequent time during the period of the reasonable useful lifetime of such equipment (as defined by the Secretary) beginning with the first month for which payment is made for the rental of such equipment under clause (i), the supplier shall supply the equipment without charge to the individual or the program under this title during the remainder of such period, other than payment for maintenance and servicing during such period which would otherwise have been paid if the

individual had accepted title to such equipment. The previous sentence shall not affect the payment of amounts under this part for such equipment after the end of such period of the reasonable useful lifetime of the equipment.

''(dd) PAYMENTS.—Maintenance and servicing payments shall be made in accordance with clause (iv), in the case of a supplier that transfers title to the Group 3 Support Surface under this subclause, after such transfer and, in the case of an individual who rejects transfer of title under this subclause, after the end of the period of medical need during which payment is made under clause (i).''; and

(2) in clause (iv), by inserting ''or, in the case of an individual who rejects transfer of title to a Group 3 Support Surface under clause (ii), after the end of the period of medical need during which pay-

ment is made under clause (i),'' after ''under clause (ii)''.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to durable medical equipment not later than January 1, 2011.

SEC. 1142. EXTENSION OF PAYMENT RULE FOR BRACHYTHERAPY.

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

SEC. 1143. HOME INFUSION THERAPY REPORT TO CONGRESS.

Not later than July 1, 2011, the Medicare Payment Advisory Commission shall submit to Congress a report on the following:

(1) The scope of coverage for home infusion therapy in the fee-for-service Medicare program under title XVIII of the Social Security Act, Medicare Advantage under part C of such title, the veteran's health care program under chapter 17 of title 38, United States Code, and among private payers, including an analysis of the scope of services pro-

vided by home infusion therapy providers to their patients in such programs.

(2) The benefits and costs of providing such coverage under the Medicare program, including a calculation of the potential savings achieved through avoided or shortened hospital and nursing home stays as a result of Medicare coverage of home infusion therapy.

(3) An assessment of sources of data on the costs of home infusion therapy that might be used to construct payment mechanisms in the Medicare program.

(4) Recommendations, if any, on the structure of a payment system under the Medicare program for home infusion therapy, including an analysis of the payment methodologies used under Medicare Advantage plans and private health plans for the provision of home infusion therapy and their applicability to the Medicare program.

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

(a) COST REPORTING.—

(1) IN GENERAL.—Section 1833(i) of the Social Security Act (42 U.S.C. 1395l(i)) is amended by adding at the end the following new paragraph:

''(8) The Secretary shall require, as a condition of the agreement described in section 1832(a)(2)(F)(i), the submission of such cost report as the Secretary may specify, taking into account the requirements for such reports under section 1815 in the case of a hospital.''.

(2) DEVELOPMENT OF COST REPORT.—Not later than 3 years after the date of the enactment of this Act, the Secretary of Health and Human Services shall develop a cost report form for use under section 1833(i)(8) of the Social Security Act, as added by paragraph (1).

(3) AUDIT REQUIREMENT.—The Secretary shall provide for periodic auditing of cost reports submitted under section 1833(i)(8) of the Social Security Act, as added by paragraph (1).

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

(b) ADDITIONAL DATA ON QUALITY.—

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

(A) in subparagraph (B), by inserting ''subject to subparagraph (C),'' after ''may otherwise provide,''; and

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

''(C) Under subparagraph (B) the Secretary shall require the reporting of such additional data relating to quality of services furnished in an ambulatory surgical facility, including data on health care associated infections, as the Secretary may specify.''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall to reporting for years beginning with 2012.

SEC. 1145. TREATMENT OF CERTAIN CANCER HOSPITALS.

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

''(18) AUTHORIZATION OF ADJUSTMENT FOR CANCER HOSPITALS.—

''(A) STUDY.—The Secretary shall conduct a study to determine if, under the system under this subsection, costs incurred by hospitals described in section 1886(d)(1)(B)(v) with respect

to ambulatory payment classification groups exceed those costs incurred by other hospitals furnishing services under this subsection (as determined appropriate by the Secretary).

''(B) AUTHORIZATION OF ADJUSTMENT.—Insofar as the Secretary determines under subparagraph (A) that costs incurred by hospitals described in section 1886(d)(1)(B)(v) exceed those costs incurred by other hospitals furnishing services under this subsection, the Secretary shall provide for an appropriate adjustment under paragraph (2)(E) to reflect those higher costs effective for services furnished on or after January 1, 2011.''.

SEC. 1146. PAYMENT FOR IMAGING SERVICES.

(a) ADJUSTMENT IN PRACTICE EXPENSE TO REFLECT A PRESUMED LEVEL OF UTILIZATION.—Section 1848 of the Social Security Act (42 U.S.C. 1395w–4) is amended—

(1) in subsection (b)(4)—

(A) in subparagraph (B), by striking ''subparagraph (A)'' and inserting ''this paragraph''; and

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

"(C) ADJUSTMENT IN PRACTICE EXPENSE TO REFLECT A PRESUMED LEVEL OF UTILIZATION.—Consistent with the methodology for computing the number of practice expense relative value units under subsection (c)(2)(C)(ii) with respect to advanced diagnostic imaging services (as defined in section 1834(e)(1)(B)) furnished on or after January 1, 2011, the Secretary shall adjust such number of units so it reflects a presumed rate of utilization of imaging equipment of 75 percent."; and

(2) in subsection (c)(2)(B)(v)), by adding at the end the following new subclause:

"(III) CHANGE IN PRESUMED UTILIZATION LEVEL OF CERTAIN ADVANCED DIAGNOSTIC IMAGING SERVICES.—Effective for fee schedules established beginning with 2011, reduced expenditures attributable to the presumed utilization of 75 percent under subsection (b)(4)(C) instead of a presumed utilization of imaging equipment of 50 percent.".

(b) ADJUSTMENT IN TECHNICAL COMPONENT "DISCOUNT" ON SINGLE-SESSION IMAGING TO CONSECUTIVE

BODY PARTS.—Section 1848 of such Act (42 U.S.C. 1395w–4) is further amended—

(1) in subsection (b)(4), by adding at the end the following new subparagraph:

"(D) ADJUSTMENT IN TECHNICAL COMPONENT DISCOUNT ON SINGLE-SESSION IMAGING INVOLVING CONSECUTIVE BODY PARTS.—For services furnished on or after January 1, 2011, the Secretary shall increase the reduction in expenditures attributable to the multiple procedure payment reduction applicable to the technical component for imaging under the final rule published by the Secretary in the Federal Register on November 21, 2005 (part 405 of title 42, Code of Federal Regulations) from 25 percent to 50 percent."; and

(2) in subsection (c)(2)(B)(v), by adding at the end the following new subclause:

"(III) ADDITIONAL REDUCED PAYMENT FOR MULTIPLE IMAGING PROCEDURES.—Effective for fee schedules established beginning with 2011, reduced expenditures attributable to the increase in the multiple procedure payment reduction from 25

percent to 50 percent as described in subsection (b)(4)(D).''.

SEC. 1147. 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 sentence: ''The requirement for a surety bond described in subparagraph (B) shall not apply in the case of a pharmacy or supplier that exclusively furnishes eyeglasses or contact lenses described in section 1861(s)(8) if the pharmacy or supply 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 supplier number (as described in the first sentence of this paragraph) for at least 5 years, and if a final adverse action (as defined in section 424.57(a) of title 42, Code of Federal Regulations) has never been imposed for such pharmacy or supplier.''.

(b) ENSURING SUPPLY OF OXYGEN EQUIPMENT .—

(1) IN GENERAL.—Section 1834(a)(5)(F) of the Social Security Act (42 U.S.C. 1395m(a)(5)(F)) is amended—

(A) in clause (ii), by striking ''After the'' and inserting ''Except as provided in clause (iii), after the''; and

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

''(iii) CONTINUATION OF SUPPLY.—In the case of a supplier furnishing such equipment to an individual under this subsection as of the 27th month of the 36 months described in clause (i), the supplier furnishing such equipment as of such month shall continue to furnish such equipment to such individual (either directly or though arrangements with other suppliers of such equipment) during any subsequent period of medical need for the remainder of the reasonable useful lifetime of the equipment, as determined by the Secretary, regardless of the location of the individual, unless another supplier has accepted responsibility for continuing to furnish such equipment during the remainder of such period.''.

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall take effect as of the date of

the enactment of this Act and shall apply to the furnishing of equipment to individuals for whom the 27th month of a continuous period of use of oxygen equipment described in section 1834(a)(5)(F) of the Social Security Act occurs on or after July 1, 2010.

(c) TREATMENT OF CURRENT ACCREDITATION APPLICATIONS.—Section 1834(a)(20)(F) of such Act (42 U.S.C. 1395m(a)(20)(F)) is amended—

(1) in clause (i)—

(A) by striking ''clause (ii)'' and inserting ''clauses (ii) and (iii)''; and

(B) by striking ''and'' at the end;

(2) by striking the period at the end of clause (ii)(II) and by inserting a semicolon;

(3) by inserting after clause (ii) the following new clauses:

''(iii) the requirement for accreditation described in clause (i) shall not apply for purposes of supplying diabetic testing supplies, canes, and crutches in the case of a pharmacy that is enrolled under section 1866(j) as a supplier of durable medical equipment, prosthetics, orthotics, and supplies; and

''(iv) a supplier that has submitted an application for accreditation before August 1, 2009, shall retain the supplier's provider or supplier number until an independent accreditation organization determines if such supplier complies with requirements under this paragraph.''; and

(4) by adding at the end the following new sentence: ''Nothing in clauses (iii) and (iv) shall be construed as affecting the application of an accreditation requirement for suppliers to qualify for bidding in a competitive acquisition area under section 1847,''.

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

''(iv) EXCEPTION FOR BANKRUPTCY.—If a supplier who furnishes oxygen and oxygen equipment to an individual is declared bankrupt and its assets are liquidated and at the time of such declaration and liquidation more than 24 months of rental payments have been made, such in-

dividual may begin a new 36-month rental period under this subparagraph with another supplier of oxygen.''.

SEC. 1148. MEDPAC STUDY AND REPORT ON BONE MASS MEASUREMENT.

(a) IN GENERAL.—The Medicare Payment Advisory Commission shall conduct a study regarding bone mass measurement, including computed tomography, duel-energy x-ray absorptriometry, and vertebral fracture assessment. The study shall focus on the following:

(1) An assessment of the adequacy of Medicare payment rates for such services, taking into account costs of acquiring the necessary equipment, professional work time, and practice expense costs.

(2) The impact of Medicare payment changes since 2006 on beneficiary access to bone mass measurement benefits in general and in rural and minority communities specifically.

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

(4) In conjunction with the findings under (3), recommendations, if necessary, regarding methods

for reaching appropriate use of bone mass measurement studies among Medicare beneficiaries.

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

SEC. 1149. TIMELY ACCESS TO POST-MASTECTOMY ITEMS.

(a) IN GENERAL.—Section 1834(h)(1) of the Social Security Act (42 U.S.C. 1395m) is amended—

(1) by redesignating subparagraph (H) as subparagraph (I); and

(2) by inserting after subparagraph (G) the following new subparagraph:

"(H) SPECIAL PAYMENT RULE FOR POST-MASTECTOMY EXTERNAL BREAST PROSTHESIS GARMENTS.—Payment for post-mastectomy external breast prosthesis garments shall be made regardless of whether such items are supplied to the beneficiary prior to or after the mastectomy procedure or other breast cancer surgical procedure. The Secretary shall develop policies to ensure appropriate beneficiary access and utiliza-

tion safeguards for such items supplied to a beneficiary prior to the mastectomy or other breast cancer surgical procedure.''

(b) EFFECTIVE DATE.—This amendment shall apply not later than January 1, 2011.

SEC. 1149A. PAYMENT FOR BIOSIMILAR BIOLOGICAL PRODUCTS.

(a) IN GENERAL.—Section 1847A of the Social Security Act (42 U.S.C. 1395w–3a) is amended—

(1) in subsection (b)(1)—

(A) in subparagraph (A), by striking ''or'' at the end;

(B) in subparagraph (B), by striking the period at the end and inserting ''; or''; and

(C) by adding at the end the following new subparagraph:

''(C) in the case of one or more interchangeable biological products (as defined in subsection (c)(6)(I)) and their reference biological product (as defined in subsection (c)(6)(J)), which shall be included in the same billing and payment code, the sum of—

''(i) the average sales price as determined using the methodology described in paragraph (6) applied to such interchange-

able and reference products for all National Drug Codes assigned to such products in the same manner as such paragraph (6) is applied to multiple source drugs; and

''(ii) 6 percent of the amount determined under clause (i);

''(D) in the case of a biosimilar biological product (as defined in subsection (c)(6)(H)), the sum of—

''(i) the average sales price as determined using the methodology described in paragraph (4) applied to such biosimilar biological product for all National Drug Codes assigned to such product in the same manner as such paragraph (4) is applied to a single source drug; and

''(ii) 6 percent of the amount determined under paragraph (4) or the amount determined under subparagraph (C)(ii), as the case may be, for the reference biological product (as defined in subsection (c)(6)(J)); or

''(E) in the case of a reference biological product for both an interchangeable biological

product and a biosimilar product, the amount determined in subparagraph (C).''; and

(2) in subsection (c)(6)—

(A) by amending subparagraph (D)(i) to read as follows:

''(i) a biological, including a reference biological product for a biosimilar product, but excluding—

''(I) a biosimilar biological product;

''(II) an interchangeable biological product;

''(III) a reference biological product for an interchangeable biological product; and

''(IV) a reference biological product for both an interchangeable biological product and a biosimilar product; or''; and

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

''(H) BIOSIMILAR BIOLOGICAL PRODUCT.—The term 'biosimilar biological product' means a biological product licensed as a biosimilar bio-

logical product under section 351(k) of the Public Health Service Act.

''(I) INTERCHANGEABLE BIOLOGICAL PRODUCT.—The term 'interchangeable biological product' means a biological product licensed as an interchangeable biological product under section 351(k) of the Public Health Service Act

''(J) REFERENCE BIOLOGICAL PRODUCT.—The term 'reference biological product' means the biological product that is referred to in the application for a biosimilar or interchangeable biological product licensed under section 351(k) of the Public Health Service Act.''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to payments for biosimilar biological products, interchangeable biological products, and reference biological products beginning with the first day of the second calendar quarter after the date of the enactment of this Act.

SEC. 1149B. STUDY AND REPORT ON DME COMPETITIVE BIDDING PROCESS.

(a) STUDY.—The Comptroller General of the United States shall conduct a study to evaluate the potential establishment of a program under Medicare under title XVIII of the Social Security Act to acquire durable med-

ical equipment and supplies through a competitive bidding process among manufacturers of such equipment and supplies. Such study shall address the following:

(1) Identification of types of durable medical equipment and supplies that would be appropriate for bidding under such a program.

(2) Recommendations on how to structure such an acquisition program in order to promote fiscal responsibility while also ensuring beneficiary access to high quality equipment and supplies.

(3) Recommendations on how such a program could be phased-in and on what geographic level would bidding be most appropriate.

(4) In addition to price, recommendations on criteria that could be factored into the bidding process.

(5) Recommendations on how suppliers could be compensated for furnishing and servicing equipment and supplies acquired under such a program.

(6) Comparison of such a program to the current competitive bidding program under Medicare for durable medical equipment, as well as any other similar Federal acquisition programs, such as the General Services Administration's vehicle purchasing program.

(7) Any other consideration relevant to the acquisition, supply, and service of durable medical equipment and supplies that is deemed appropriate by the Comptroller General.

(b) REPORT.—Not later than 12 months after the date of the enactment of this Act, the Comptroller General of the United States shall submit to Congress a report on the findings of the study under subsection (a).

Subtitle C—Provisions Related to Medicare Parts A and B

SEC. 1151. REDUCING POTENTIALLY PREVENTABLE HOSPITAL READMISSIONS.

(a) HOSPITALS.—

(1) IN GENERAL.—Section 1886 of the Social Security Act (42 U.S.C. 1395ww), as amended by section 1103(a), is amended by adding at the end the following new subsection:

''(p) ADJUSTMENT TO HOSPITAL PAYMENTS FOR EXCESS READMISSIONS.—

''(1) IN GENERAL.—With respect to payment for discharges from an applicable hospital (as defined in paragraph (5)(C)) occurring during a fiscal year beginning on or after October 1, 2011, in order to account for excess readmissions in the hospital, the Secretary shall reduce the payments that would

otherwise be made to such hospital under subsection (d) (or section 1814(b)(3), as the case may be) for such a discharge by an amount equal to the product of—

''(A) the base operating DRG payment amount (as defined in paragraph (2)) for the discharge; and

''(B) the adjustment factor (described in paragraph (3)(A)) for the hospital for the fiscal year.

''(2) BASE OPERATING DRG PAYMENT AMOUNT.—

''(A) IN GENERAL.—Except as provided in subparagraph (B), for purposes of this subsection, the term 'base operating DRG payment amount' means, with respect to a hospital for a fiscal year, the payment amount that would otherwise be made under subsection (d) for a discharge if this subsection did not apply, reduced by any portion of such amount that is attributable to payments under subparagraphs (B) and (F) of paragraph (5).

''(B) ADJUSTMENTS.—For purposes of subparagraph (A), in the case of a hospital that is paid under section 1814(b)(3), the term 'base

operating DRG payment amount' means the payment amount under such section.

''(3) ADJUSTMENT FACTOR.—

''(A) IN GENERAL.—For purposes of paragraph (1), the adjustment factor under this paragraph for an applicable hospital for a fiscal year is equal to the greater of—

''(i) the ratio described in subparagraph (B) for the hospital for the applicable period (as defined in paragraph (5)(D)) for such fiscal year; or

''(ii) the floor adjustment factor specified in subparagraph (C).

''(B) RATIO.—The ratio described in this subparagraph for a hospital for an applicable period is equal to 1 minus the ratio of—

''(i) the aggregate payments for excess readmissions (as defined in paragraph (4)(A)) with respect to an applicable hospital for the applicable period; and

''(ii) the aggregate payments for all discharges (as defined in paragraph (4)(B)) with respect to such applicable hospital for such applicable period.

''(C) FLOOR ADJUSTMENT FACTOR.—For purposes of subparagraph (A), the floor adjustment factor specified in this subparagraph for—

''(i) fiscal year 2012 is 0.99;

''(ii) fiscal year 2013 is 0.98;

''(iii) fiscal year 2014 is 0.97; or

''(iv) a subsequent fiscal year is 0.95.

''(4) AGGREGATE PAYMENTS, EXCESS READMISSION RATIO DEFINED.—For purposes of this subsection:

''(A) AGGREGATE PAYMENTS FOR EXCESS READMISSIONS.—The term 'aggregate payments for excess readmissions' means, for a hospital for a fiscal year, the sum, for applicable conditions (as defined in paragraph (5)(A)), of the product, for each applicable condition, of—

''(i) the base operating DRG payment amount for such hospital for such fiscal year for such condition;

''(ii) the number of admissions for such condition for such hospital for such fiscal year; and

''(iii) the excess readmissions ratio (as defined in subparagraph (C)) for such hos-

pital for the applicable period for such fiscal year minus 1.

''(B) AGGREGATE PAYMENTS FOR ALL DISCHARGES.—The term 'aggregate payments for all discharges' means, for a hospital for a fiscal year, the sum of the base operating DRG payment amounts for all discharges for all conditions from such hospital for such fiscal year.

''(C) EXCESS READMISSION RATIO.—

''(i) IN GENERAL.—Subject to clauses (ii) and (iii), the term 'excess readmissions ratio' means, with respect to an applicable condition for a hospital for an applicable period, the ratio (but not less than 1.0) of—

''(I) the risk adjusted readmissions based on actual readmissions, as determined consistent with a readmission measure methodology that has been endorsed under paragraph (5)(A)(ii)(I), for an applicable hospital for such condition with respect to the applicable period; to

''(II) the risk adjusted expected readmissions (as determined con-

sistent with such a methodology) for such hospital for such condition with respect to such applicable period.

''(ii) EXCLUSION OF CERTAIN READMISSIONS.—For purposes of clause (i), with respect to a hospital, excess readmissions shall not include readmissions for an applicable condition for which there are fewer than a minimum number (as determined by the Secretary) of discharges for such applicable condition for the applicable period and such hospital.

''(iii) ADJUSTMENT.—In order to promote a reduction over time in the overall rate of readmissions for applicable conditions, the Secretary may provide, beginning with discharges for fiscal year 2014, for the determination of the excess readmissions ratio under subparagraph (C) to be based on a ranking of hospitals by readmission ratios (from lower to higher readmission ratios) normalized to a benchmark that is lower than the 50th percentile.

''(5) DEFINITIONS.—For purposes of this subsection:

''(A) APPLICABLE CONDITION.—The term 'applicable condition' means, subject to subparagraph (B), a condition or procedure selected by the Secretary among conditions and procedures for which—

''(i) readmissions (as defined in subparagraph (E)) that represent conditions or procedures that are high volume or high expenditures under this title (or other criteria specified by the Secretary); and

''(ii) measures of such readmissions—

''(I) have been endorsed by the entity with a contract under section 1890(a); and

''(II) such endorsed measures have appropriate exclusions for readmissions that are unrelated to the prior discharge (such as a planned readmission or transfer to another applicable hospital).

''(B) EXPANSION OF APPLICABLE CONDITIONS.—Beginning with fiscal year 2013, the Secretary shall expand the applicable conditions beyond the 3 conditions for which measures have been endorsed as described in subpara-

graph (A)(ii)(I) as of the date of the enactment of this subsection to the additional 4 conditions that have been so identified by the Medicare Payment Advisory Commission in its report to Congress in June 2007 and to other conditions and procedures which may include an all-condition measure of readmissions, as determined appropriate by the Secretary. In expanding such applicable conditions, the Secretary shall seek the endorsement described in subparagraph (A)(ii)(I) but may apply such measures without such an endorsement.

''(C) APPLICABLE HOSPITAL.—The term 'applicable hospital' means a subsection (d) hospital or a hospital that is paid under section 1814(b)(3).

''(D) APPLICABLE PERIOD.—The term 'applicable period' means, with respect to a fiscal year, such period as the Secretary shall specify for purposes of determining excess readmissions.

''(E) READMISSION.—The term 'readmission' means, in the case of an individual who is discharged from an applicable hospital, the admission of the individual to the same or another

applicable hospital within a time period specified by the Secretary from the date of such discharge. Insofar as the discharge relates to an applicable condition for which there is an endorsed measure described in subparagraph (A)(ii)(I), such time period (such as 30 days) shall be consistent with the time period specified for such measure.

''(6) LIMITATIONS ON REVIEW.—There shall be no administrative or judicial review under section 1869, section 1878, or otherwise of—

''(A) the determination of base operating DRG payment amounts;

''(B) the methodology for determining the adjustment factor under paragraph (3), including excess readmissions ratio under paragraph (4)(C), aggregate payments for excess readmissions under paragraph (4)(A), and aggregate payments for all discharges under paragraph (4)(B), and applicable periods and applicable conditions under paragraph (5);

''(C) the measures of readmissions as described in paragraph (5)(A)(ii); and

''(D) the determination of a targeted hospital under paragraph (8)(B)(i), the increase in

payment under paragraph (8)(B)(ii), the aggregate cap under paragraph (8)(C)(i), the hospital-specific limit under paragraph (8)(C)(ii), and the form of payment made by the Secretary under paragraph (8)(D).

''(7) MONITORING INAPPROPRIATE CHANGES IN ADMISSIONS PRACTICES.—The Secretary shall monitor the activities of applicable hospitals to determine if such hospitals have taken steps to avoid patients at risk in order to reduce the likelihood of increasing readmissions for applicable conditions or taken other inappropriate steps involving readmissions or transfers. If the Secretary determines that such a hospital has taken such a step, after notice to the hospital and opportunity for the hospital to undertake action to alleviate such steps, the Secretary may impose an appropriate sanction.

''(8) ASSISTANCE TO CERTAIN HOSPITALS.—

''(A) IN GENERAL.—For purposes of providing funds to applicable hospitals to take steps described in subparagraph (E) to address factors that may impact readmissions of individuals who are discharged from such a hospital, for fiscal years beginning on or after October 1, 2011, the Secretary shall make a pay-

ment adjustment for a hospital described in subparagraph (B), with respect to each such fiscal year, by a percent estimated by the Secretary to be consistent with subparagraph (C). The Secretary shall provide priority to hospitals that serve Medicare beneficiaries at highest risk for readmission or for a poor transition from such a hospital to a post-hospital site of care.

''(B) TARGETED HOSPITALS.—Subparagraph (A) shall apply to an applicable hospital that—

''(i) had (or, in the case of an 1814(b)(3) hospital, otherwise would have had) a disproportionate patient percentage (as defined in section 1886(d)(5)(F)) of at least 30 percent, using the latest available data as estimated by the Secretary; and

''(ii) provides assurances satisfactory to the Secretary that the increase in payment under this paragraph shall be used for purposes described in subparagraph (E).

''(C) CAPS.—

''(i) AGGREGATE CAP.—The aggregate amount of the payment adjustment under

this paragraph for a fiscal year shall not exceed 5 percent of the estimated difference in the spending that would occur for such fiscal year with and without application of the adjustment factor described in paragraph (3) and applied pursuant to paragraph (1).

''(ii) HOSPITAL-SPECIFIC LIMIT.—The aggregate amount of the payment adjustment for a hospital under this paragraph shall not exceed the estimated difference in spending that would occur for such fiscal year for such hospital with and without application of the adjustment factor described in paragraph (3) and applied pursuant to paragraph (1).

''(D) FORM OF PAYMENT.—The Secretary may make the additional payments under this paragraph on a lump sum basis, a periodic basis, a claim by claim basis, or otherwise.

''(E) USE OF ADDITIONAL PAYMENT.—

''(i) IN GENERAL.—Funding under this paragraph shall be used by targeted hospitals for activities designed to address the patient noncompliance issues that re-

sult in higher than normal readmission rates, including transitional care services described in clause (ii) and any or all of the other activities described in clause (iii).

''(ii) TRANSITIONAL CARE SERVICES.—The transitional care services described in this clause are transitional care services furnished by a qualified transitional care provider, such as a nurse or other health professional, who meets relevant experience and training requirements as specified by the Secretary that support a beneficiary under this section beginning on the date of an individual's admission to a hospital for inpatient hospital services and ending at the latest on the last day of the 90-day period beginning on the date of the individual's discharge from the applicable hospital. The Secretary shall determine and update services to be included in transitional care services under this clause as appropriate, based on evidence of their effectiveness in reducing hospital readmissions and improving health outcomes. Such services shall include the following:

''(I) Conduct of an assessment prior to discharge, which assessment may include an assessment of the individual's physical and mental condition, cognitive and functional capacities, medication regimen and adherence, social and environmental needs, and primary caregiver needs and resources.

''(II) Development of a evidence-based plan of transitional care for the individual developed after consultation with the individual and the individual's primary caregiver and other health team members, as appropriate. Such plan shall include a list of current therapies prescribed, treatment goals and may include other items or elements as determined by the Secretary, such as identifying list of potential health risks and future services for both the individual and any primary caregiver.

''(iii) OTHER ACTIVITIES.—The other activities described in this clause are the following:

''(I) Providing other care coordination services not described under clause (ii).

''(II) Hiring translators and interpreters.

''(III) Increasing services offered by discharge planners.

''(IV) Ensuring that individuals receive a summary of care and medication orders upon discharge.

''(V) Developing a quality improvement plan to assess and remedy preventable readmission rates.

''(VI) Assigning appropriate follow-up care for discharged individuals.

''(VII) Doing other activities as determined appropriate by the Secretary.

''(F) GAO REPORT ON USE OF FUNDS.—Not later than 3 years after the date on which funds are first made available under this paragraph, the Comptroller General of the United

States shall submit to Congress a report on the use of such funds. Such report shall consider information on the effective uses of such funds, how the uses of such funds affected hospital readmission rates (including at 6 months post-discharge), health outcomes and quality, reductions in expenditures under this title and the experiences of beneficiaries, primary caregivers, and providers, as well as any appropriate recommendations.''.

(b) APPLICATION TO CRITICAL ACCESS HOSPITALS.—Section 1814(l) of the Social Security Act (42 U.S.C. 1395f(l)) is amended—

(1) in paragraph (5)—

(A) by striking ''and'' at the end of subparagraph (C);

(B) by striking the period at the end of subparagraph (D) and inserting ''; and'';

(C) by inserting at the end the following new subparagraph:

''(E) the methodology for determining the adjustment factor under paragraph (5), including the determination of aggregate payments for actual and expected readmissions, applicable periods, applicable conditions and measures of readmissions.''; and

(D) by redesignating such paragraph as paragraph (6); and

(2) by inserting after paragraph (4) the following new paragraph:

''(5) The adjustment factor described in section 1886(p)(3) shall apply to payments with respect to a critical access hospital with respect to a cost reporting period beginning in fiscal year 2012 and each subsequent fiscal year (after application of paragraph (4) of this subsection) in a manner similar to the manner in which such section applies with respect to a fiscal year to an applicable hospital as described in section 1886(p)(2).''.

(c) POST ACUTE CARE PROVIDERS.—

(1) INTERIM POLICY.—

(A) IN GENERAL.—With respect to a readmission to an applicable hospital or a critical access hospital (as described in section 1814(l) of the Social Security Act) from a post acute care provider (as defined in paragraph (3)) and such a readmission is not governed by section 412.531 of title 42, Code of Federal Regulations, if the claim submitted by such a post-acute care provider under title XVIII of the Social Security Act indicates that the individual was readmitted to a hospital from such a post-

acute care provider or admitted from home and under the care of a home health agency within 30 days of an initial discharge from an applicable hospital or critical access hospital, the payment under such title on such claim shall be the applicable percent specified in subparagraph (B) of the payment that would otherwise be made under the respective payment system under such title for such post-acute care provider if this subsection did not apply. In applying the previous sentence, the Secretary shall exclude a period of 1 day from the date the individual is first admitted to or under the care of the post-acute care provider.

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

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

(ii) for fiscal or rate year 2013 is 0.993; and

(iii) for fiscal or rate year 2014 is 0.99.

(C) EFFECTIVE DATE.—Subparagraph (1) shall apply to discharges or services furnished

(as the case may be with respect to the applicable post acute care provider) on or after the first day of the fiscal year or rate year, beginning on or after October 1, 2011, with respect to the applicable post acute care provider.

(2) DEVELOPMENT AND APPLICATION OF PERFORMANCE MEASURES.—

(A) IN GENERAL.—The Secretary of Health and Human Services shall develop appropriate measures of readmission rates for post acute care providers. The Secretary shall seek endorsement of such measures by the entity with a contract under section 1890(a) of the Social Security Act but may adopt and apply such measures under this paragraph without such an endorsement. The Secretary shall expand such measures in a manner similar to the manner in which applicable conditions are expanded under paragraph (5)(B) of section 1886(p) of the Social Security Act, as added by subsection (a).

(B) IMPLEMENTATION.—The Secretary shall apply, on or after October 1, 2014, with respect to post acute care providers, policies similar to the policies applied with respect to

applicable hospitals and critical access hospitals under the amendments made by subsection (a). The provisions of paragraph (1) shall apply with respect to any period on or after October 1, 2014, and before such application date described in the previous sentence in the same manner as such provisions apply with respect to fiscal or rate year 2014.

(C) MONITORING AND PENALTIES.—The provisions of paragraph (7) of such section 1886(p) shall apply to providers under this paragraph in the same manner as they apply to hospitals under such section.

(3) DEFINITIONS.—For purposes of this subsection:

(A) POST ACUTE CARE PROVIDER.—The term ''post acute care provider'' means—

(i) a skilled nursing facility (as defined in section 1819(a) of the Social Security Act);

(ii) an inpatient rehabilitation facility (described in section 1886(h)(1)(A) of such Act);

(iii) a home health agency (as defined in section 1861(o) of such Act); and

(iv) a long term care hospital (as defined in section 1861(ccc) of such Act).

(B) OTHER TERMS .—The terms ''applicable condition'', ''applicable hospital'', and ''readmission'' have the meanings given such terms in section 1886(p)(5) of the Social Security Act, as added by subsection (a)(1).

(d) PHYSICIANS.—

(1) STUDY.—The Secretary of Health and Human Services shall conduct a study to determine how the readmissions policy described in the previous subsections could be applied to physicians.

(2) CONSIDERATIONS.—In conducting the study, the Secretary shall consider approaches such as—

(A) creating a new code (or codes) and payment amount (or amounts) under the fee schedule in section 1848 of the Social Security Act (in a budget neutral manner) for services furnished by an appropriate physician who sees an individual within the first week after discharge from a hospital or critical access hospital;

(B) developing measures of rates of readmission for individuals treated by physicians;

(C) applying a payment reduction for physicians who treat the patient during the initial admission that results in a readmission; and

(D) methods for attributing payments or payment reductions to the appropriate physician or physicians.

(3) REPORT.—The Secretary shall issue a public report on such study not later than the date that is one year after the date of the enactment of this Act.

(e) FUNDING.—For purposes of carrying out the provisions of this section, in addition to funds otherwise available, out of any funds in the Treasury not otherwise appropriated, there are appropriated to the Secretary of Health and Human Services for the Center for Medicare & Medicaid Services Program Management Account $25,000,000 for each fiscal year beginning with 2010. Amounts appropriated under this subsection for a fiscal year shall be available until expended.

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

(a) PLAN.—

(1) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall develop a detailed plan to reform

payment for post acute care (PAC) services under the Medicare program under title XVIII of the Social Security Act (in this section referred to as the ''Medicare program)''. The goals of such payment reform are to—

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

(B) improve outcomes for individuals such as reducing the need for readmission to hospitals from providers of such services.

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

(3) POST ACUTE SERVICES.—For purposes of this section, the term ''post acute services'' means services for which payment may be made under the Medicare program that are furnished by skilled nursing facilities, inpatient rehabilitation facilities, long term care hospitals, hospital based outpatient rehabilitation facilities and home health agencies to an individual after discharge of such individual from

a hospital, and such other services determined appropriate by the Secretary.

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

(1) The nature of payments under a post acute care bundle, including the type of provider or entity to whom payment should be made, the scope of activities and services included in the bundle, whether payment for physicians' services should be included in the bundle, and the period covered by the bundle.

(2) Whether the payment should be consolidated with the payment under the inpatient prospective system under section 1886 of the Social Security Act (in this section referred to as MS–DRGs) or a separate payment should be established for such bundle, and if a separate payment is established, whether it should be made only upon use of post acute care services or for every discharge.

(3) Whether the bundle should be applied across all categories of providers of inpatient services (including critical access hospitals) and post acute care services or whether it should be limited to certain categories of providers, services, or discharges, such as high volume or high cost MS–DRGs.

(4) The extent to which payment rates could be established to achieve offsets for efficiencies that could be expected to be achieved with a bundle payment, whether such rates should be established on a national basis or for different geographic areas, should vary according to discharge, case mix, outliers, and geographic differences in wages or other appropriate adjustments, and how to update such rates.

(5) The nature of protections needed for individuals under a system of bundled payments to ensure that individuals receive quality care, are furnished the level and amount of services needed as determined by an appropriate assessment instrument, are offered choice of provider, and the extent to which transitional care services would improve quality of care for individuals and the functioning of a bundled post-acute system.

(6) The nature of relationships that may be required between hospitals and providers of post acute care services to facilitate bundled payments, including the application of gainsharing, anti-referral, anti-kickback, and anti-trust laws.

(7) Quality measures that would be appropriate for reporting by hospitals and post acute providers

(such as measures that assess changes in functional status and quality measures appropriate for each type of post acute services provider including how the reporting of such quality measures could be coordinated with other reporting of such quality measures by such providers otherwise required).

(8) How cost-sharing for a post acute care bundle should be treated relative to current rules for cost-sharing for inpatient hospital, home health, skilled nursing facility, and other services.

(9) How other programmatic issues should be treated in a post acute care bundle, including rules specific to various types of post-acute providers such as the post-acute transfer policy, three-day hospital stay to qualify for services furnished by skilled nursing facilities, and the coordination of payments and care under the Medicare program and the Medicaid program.

(10) Such other issues as the Secretary deems appropriate.

(c) CONSULTATIONS AND ANALYSIS.—

(1) CONSULTATION WITH STAKEHOLDERS.—In developing the plan under subsection (a)(1), the Secretary shall consult with relevant stakeholders and shall consider experience with such research studies

and demonstrations that the Secretary determines appropriate.

(2) ANALYSIS AND DATA COLLECTION.—In developing such plan, the Secretary shall—

(A) analyze the issues described in subsection (b) and other issues that the Secretary determines appropriate;

(B) analyze the impacts (including geographic impacts) of post acute service reform approaches, including bundling of such services on individuals, hospitals, post acute care providers, and physicians;

(C) use existing data (such as data submitted on claims) and collect such data as the Secretary determines are appropriate to develop such plan required in this section; and

(D) if patient functional status measures are appropriate for the analysis, to the extent practical, build upon the CARE tool being developed pursuant to section 5008 of the Deficit Reduction Act of 2005.

(d) ADMINISTRATION.—

(1) FUNDING.—For purposes of carrying out the provisions of this section, in addition to funds otherwise available, out of any funds in the Treasury

not otherwise appropriated, there are appropriated to the Secretary for the Center for Medicare & Medicaid Services Program Management Account $15,000,000 for each of the fiscal years 2010 through 2012. Amounts appropriated under this paragraph for a fiscal year shall be available until expended.

(2) EXPEDITED DATA COLLECTION.—Chapter 35 of title 44, United States Code shall not apply to this section.

(e) PUBLIC REPORTS.—

(1) INTERIM REPORTS.—The Secretary shall issue interim public reports on a periodic basis on the plan described in subsection (a)(1), the issues described in subsection (b), and impact analyses as the Secretary determines appropriate.

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

(f) CONVERSION OF ACUTE CARE EPISODE DEMONSTRATION TO PILOT PROGRAM AND EXPANSION TO INCLUDE POST ACUTE SERVICES.—

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

''CONVERSION OF ACUTE CARE EPISODE DEMONSTRATION TO PILOT PROGRAM AND EXPANSION TO INCLUDE POST ACUTE SERVICES

''SEC. 1866D. (a) CONVERSION AND EXPANSION.—

''(1) IN GENERAL.—By not later than January 1, 2011, the Secretary shall, for the purpose of promoting the use of bundled payments to promote efficient, coordinated, and high quality delivery of care—

''(A) convert the acute care episode demonstration program conducted under section 1866C to a pilot program; and

''(B) subject to subsection (c), expand such program as so converted to include post acute services and such other services the Secretary determines to be appropriate, which may include transitional services.

''(2) BUNDLED PAYMENT STRUCTURES.—

''(A) IN GENERAL.—In carrying out paragraph (1), the Secretary may apply bundled payments with respect to—

''(i) hospitals and physicians;

''(ii) hospitals and post-acute care providers;

''(iii) hospitals, physicians, and post-acute care providers; or

''(iv) combinations of post-acute providers.

''(B) FURTHER APPLICATION.—

''(i) IN GENERAL.—In carrying out paragraph (1), the Secretary shall apply bundled payments in a manner so as to include collaborative care networks and continuing care hospitals.

''(ii) COLLABORATIVE CARE NETWORK DEFINED.—For purposes of this subparagraph, the term 'collaborative care network' means a consortium of health care providers that provides a comprehensive range of coordinated and integrated health care services to low-income patient populations (including the uninsured) which may include coordinated and comprehensive care by safety net providers to reduce any unnecessary use of items and services furnished in emergency departments, manage chronic conditions, improve quality and

efficiency of care, increase preventive services, and promote adherence to post-acute and follow-up care plans.

''(iii) CONTINUING CARE HOSPITAL DEFINED.—For purposes of this subparagraph, the term 'continuing care hospital' means an entity that has demonstrated the ability to meet patient care and patient safety standards and that provides under common management the medical and rehabilitation services provided in inpatient rehabilitation hospitals and units (as defined in section 1886(d)(1)(B)(ii)), long-term care hospitals (as defined in section 1886(d)(1)(B)(iv)(I)), and skilled nursing facilities (as defined in section 1819(a)) that are located in a hospital described in section 1886(d).

''(b) SCOPE.—The Secretary shall set specific goals for the number of acute and post-acute bundling test sites under the pilot program to ensure that over time the pilot program is of sufficient size and scope to—

''(1) test the approaches under the pilot program in a variety of settings, including urban, rural, and underserved areas;

''(2) include geographic areas and additional conditions that account for significant program spending, as defined by the Secretary; and

''(3) subject to subsection (d), disseminate the pilot program rapidly on a national basis.

To the extent that the Secretary finds inpatient and post acute care bundling to be successful in improving quality and reducing costs, the Secretary shall implement such mechanisms and reforms under the pilot program on as large a geographic scale as practical and economical, consistent with subsection (e). Nothing in this subsection shall be construed as limiting the number of hospital and physician groups or the number of hospital and post-acute provider groups that may participate in the pilot program.

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

''(1) the demonstration program under section 1866C and pilot program under this section maintain or increase the quality of care received by individuals enrolled under this title; and

''(2) such demonstration program and pilot program reduce program expenditures and, based on the certification under subsection (d), that the expansion of such pilot program would result in esti-

mated spending that would be less than what spending would otherwise be in the absence of this section.

''(d) CERTIFICATION.—For purposes of subsection (c), the Chief Actuary of the Centers for Medicare & Medicaid Services shall certify whether expansion of the pilot program under this section would result in estimated spending that would be less than what spending would otherwise be in the absence of this section.

''(e) VOLUNTARY PARTICIPATION.—Nothing in this paragraph shall be construed as requiring the participation of an entity in the pilot program under this section.

''(f) EVALUATION ON COST AND QUALITY OF CARE.—The Secretary shall conduct an evaluation of the pilot program under subsection (a) to study the effect of such program on costs and quality of care. The findings of such evaluation shall be included in the final report required under section 1152(e)(2) of the Affordable Health Care for America Act.

''(g) STUDY OF ADDITIONAL BUNDLING AND EPISODE-BASED PAYMENT FOR PHYSICIANS' SERVICES.—

''(1) IN GENERAL.—The Secretary shall provide for a study of and development of a plan for testing additional ways to increase bundling of payments for physicians in connection with an episode of care, such as in connection with outpatient hospital serv-

ices or services rendered in physicians' offices, other than those provided under the pilot program.

''(2) APPLICATION.—The Secretary may implement such a plan through a demonstration program.''.

(2) CONFORMING AMENDMENT.—Section 1866C(b) of the Social Security Act (42 U.S.C. 1395cc–3(b)) is amended by striking ''The Secretary'' and inserting ''Subject to section 1866D, the Secretary''.

SEC. 1153. HOME HEALTH PAYMENT UPDATE FOR 2010.

Section 1895(b)(3)(B)(ii) of the Social Security Act (42 U.S.C. 1395fff(b)(3)(B)(ii)) is amended—

(1) in subclause (IV), by striking ''and'';

(2) by redesignating subclause (V) as subclause (VII); and

(3) by inserting after subclause (IV) the following new subclauses:

''(V) 2007, 2008, and 2009, subject to clause (v), the home health market basket percentage increase;

''(VI) 2010, subject to clause (v), 0 percent; and''.

SEC. 1154. PAYMENT ADJUSTMENTS FOR HOME HEALTH CARE.

(a) ACCELERATION OF ADJUSTMENT FOR CASE MIX CHANGES.—Section 1895(b)(3)(B) of the Social Security Act (42 U.S.C. 1395fff(b)(3)(B)) is amended—

(1) in clause (iv), by striking ''Insofar as'' and inserting ''Subject to clause (vi), insofar as''; and

(2) by adding at the end the following new clause:

''(vi) SPECIAL RULE FOR CASE MIX CHANGES FOR 2011.—

''(I) IN GENERAL.—With respect to the case mix adjustments established in section 484.220(a) of title 42, Code of Federal Regulations, the Secretary shall apply, in 2010, the adjustment established in paragraph (3) of such section for 2011, in addition to applying the adjustment established in paragraph (2) for 2010.

''(II) CONSTRUCTION.—Nothing in this clause shall be construed as limiting the amount of adjustment for case mix for 2010 or 2011 if more recent data indicate an appropriate adjustment that is greater than the

amount established in the section described in subclause (I).''.

(b) REBASING HOME HEALTH PROSPECTIVE PAYMENT AMOUNT.—Section 1895(b)(3)(A) of the Social Security Act (42 U.S.C. 1395fff(b)(3)(A)) is amended—

(1) in clause (i)—

(A) in subclause (III), by inserting ''and before 2011'' after ''after the period described in subclause (II)''; and

(B) by inserting after subclause (III) the following new subclauses:

''(IV) Subject to clause (iii)(I), for 2011, such amount (or amounts) shall be adjusted by a uniform percentage determined to be appropriate by the Secretary based on analysis of factors such as changes in the average number and types of visits in an episode, the change in intensity of visits in an episode, growth in cost per episode, and other factors that the Secretary considers to be relevant.

''(V) Subject to clause (iii)(II), for a year after 2011, such a amount (or amounts) shall be equal to the

amount (or amounts) determined under this clause for the previous year, updated under subparagraph (B).''; and

(2) by adding at the end the following new clause:

''(iii) SPECIAL RULE IN CASE OF INABILITY TO EFFECT TIMELY REBASING.—

''(I) APPLICATION OF PROXY AMOUNT FOR 2011.—If the Secretary is not able to compute the amount (or amounts) under clause (i)(IV) so as to permit, on a timely basis, the application of such clause for 2011, the Secretary shall substitute for such amount (or amounts) 95 percent of the amount (or amounts) that would otherwise be specified under clause (i)(III) if it applied for 2011.

''(II) ADJUSTMENT FOR SUBSEQUENT YEARS BASED ON DATA.—If the Secretary applies subclause (I), the Secretary before July 1, 2011, shall compare the amount (or amounts) applied under such sub-

clause with the amount (or amounts) that should have been applied under clause (i)(IV). The Secretary shall decrease or increase the prospective payment amount (or amounts) under clause (i)(V) for 2012 (or, at the Secretary's discretion, over a period of several years beginning with 2012) by the amount (if any) by which the amount (or amounts) applied under subclause (I) is greater or less, respectively, than the amount (or amounts) that should have been applied under clause (i)(IV).''.

SEC. 1155. INCORPORATING PRODUCTIVITY IMPROVEMENTS INTO MARKET BASKET UPDATE FOR HOME HEALTH SERVICES.

(a) IN GENERAL.—Section 1895(b)(3)(B) of the Social Security Act (42 U.S.C. 1395fff(b)(3)(B)) is amended—

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

(2) in clause (v)(I), by inserting ''(but not below 0)'' after ''reduced''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to home health market basket percentage increases for years beginning with 2011.

SEC. 1155A. MEDPAC STUDY ON VARIATION IN HOME HEALTH MARGINS.

(a) IN GENERAL.—The Medicare Payment Advisory Commission shall conduct a study regarding variation in performance of home health agencies in an effort to explain variation in Medicare margins for such agencies. Such study shall include an examination of at least the following issues:

(1) The demographic characteristics of individuals served and the geographic distribution associated with transportation costs.

(2) The characteristics of such agencies, such as whether such agencies operate 24 hours each day, provide charity care, or are part of an integrated health system.

(3) The socio-economic status of individuals served, such as the proportion of such individuals who are dually eligible for Medicare and Medicaid benefits.

(4) The presence of severe and or chronic disease or disability in individuals served, as evidenced by multiple discontinuous home health episodes with a high number of visits per episode.

(5) The differences in services provided, such as therapy and non-therapy services.

(b) REPORT.—Not later than June 1, 2011, the Commission shall submit a report to the Congress on the results of the study conducted under subsection (a) and shall include in the report the Commission's conclusions and recommendations, if appropriate, regarding each of the issues described in paragraphs (1), (2) and (3) of such subsection.

SEC. 1155B. PERMITTING HOME HEALTH AGENCIES TO ASSIGN THE MOST APPROPRIATE SKILLED SERVICE TO MAKE THE INITIAL ASSESSMENT VISIT UNDER A MEDICARE HOME HEALTH PLAN OF CARE FOR REHABILITATION CASES.

(a) IN GENERAL.—Notwithstanding section 484.55(a)(2) of title 42 of the Code of Federal Regulations or any other provision of law, a home health agency may determine the most appropriate skilled therapist to make the initial assessment visit for an individual who is referred (and may be eligible) for home health services under title XVIII of the Social Security Act but who does

not require skilled nursing care as long as the skilled service (for which that therapist is qualified to provide the service) is included as part of the plan of care for home health services for such individual.

(b) RULE OF CONSTRUCTION.—Nothing in subsection (a) shall be construed to provide for initial eligibility for coverage of home health services under title XVIII of the Social Security Act on the basis of a need for occupational therapy.

SEC. 1156. LIMITATION ON MEDICARE EXCEPTIONS TO THE PROHIBITION ON CERTAIN PHYSICIAN REFERRALS MADE TO HOSPITALS.

(a) IN GENERAL.—Section 1877 of the Social Security Act (42 U.S.C. 1395nn) is amended—

(1) in subsection (d)(2)—

(A) in subparagraph (A), by striking ''and'' at the end;

(B) in subparagraph (B), by striking the period at the end and inserting ''; and''; and

(C) by adding at the end the following new subparagraph:

''(C) in the case where the entity is a hospital, the hospital meets the requirements of paragraph (3)(D).'';

(2) in subsection (d)(3)—

(A) in subparagraph (B), by striking ''and'' at the end;

(B) in subparagraph (C), by striking the period at the end and inserting ''; and''; and

(C) by adding at the end the following new subparagraph:

''(D) the hospital meets the requirements described in subsection (i)(1).'';

(3) by amending subsection (f) to read as follows:

''(f) REPORTING AND DISCLOSURE REQUIREMENTS.—

''(1) IN GENERAL.—Each entity providing covered items or services for which payment may be made under this title shall provide the Secretary with the information concerning the entity's ownership, investment, and compensation arrangements, including—

''(A) the covered items and services provided by the entity, and

''(B) the names and unique physician identification numbers of all physicians with an ownership or investment interest (as described in subsection (a)(2)(A)), or with a compensation arrangement (as described in subsection

(a)(2)(B)), in the entity, or whose immediate relatives have such an ownership or investment interest or who have such a compensation relationship with the entity.

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

''(2) REQUIREMENTS FOR HOSPITALS WITH PHYSICIAN OWNERSHIP OR INVESTMENT.—In the case of a hospital that meets the requirements described in subsection (i)(1), the hospital shall—

''(A) submit to the Secretary an initial report, and periodic updates at a frequency determined by the Secretary, containing a detailed description of the identity of each physician owner and physician investor and any other owners or investors of the hospital;

''(B) require that any referring physician owner or investor discloses to the individual being referred, by a time that permits the individual to make a meaningful decision regarding

the receipt of services, as determined by the Secretary, the ownership or investment interest, as applicable, of such referring physician in the hospital; and

''(C) disclose the fact that the hospital is partially or wholly owned by one or more physicians or has one or more physician investors—

''(i) on any public website for the hospital; and

''(ii) in any public advertising for the hospital.

The information to be reported or disclosed under this paragraph shall be provided in such form, manner, and at such times as the Secretary shall specify. The requirements of this paragraph shall not apply to designated health services furnished outside the United States or to entities which the Secretary determines provide services for which payment may be made under this title very infrequently.

''(3) PUBLICATION OF INFORMATION.—The Secretary shall publish, and periodically update, the information submitted by hospitals under paragraph (2)(A) on the public Internet website of the Centers for Medicare & Medicaid Services.'';

(4) by amending subsection (g)(5) to read as follows:

''(5) FAILURE TO REPORT OR DISCLOSE INFORMATION.—

''(A) REPORTING.—Any person who is required, but fails, to meet a reporting requirement of paragraphs (1) and (2)(A) of subsection (f) is subject to a civil money penalty of not more than $10,000 for each day for which reporting is required to have been made.

''(B) DISCLOSURE.—Any physician who is required, but fails, to meet a disclosure requirement of subsection (f)(2)(B) or a hospital that is required, but fails, to meet a disclosure requirement of subsection (f)(2)(C) is subject to a civil money penalty of not more than $10,000 for each case in which disclosure is required to have been made.

''(C) APPLICATION.—The provisions of section 1128A (other than the first sentence of subsection (a) and other than subsection (b)) shall apply to a civil money penalty under subparagraphs (A) and (B) in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).''; and

(5) by adding at the end the following new subsection:

''(i) REQUIREMENTS TO QUALIFY FOR RURAL PROVIDER AND HOSPITAL OWNERSHIP EXCEPTIONS TO SELF-REFERRAL PROHIBITION.—

''(1) REQUIREMENTS DESCRIBED.—For purposes of subsection (d)(3)(D), the requirements described in this paragraph are as follows:

''(A) PROVIDER AGREEMENT.—The hospital had—

''(i) physician ownership or investment on January 1, 2009; and

''(ii) a provider agreement under section 1866 in effect on such date.

''(B) PROHIBITION ON PHYSICIAN OWNERSHIP OR INVESTMENT.—The percentage of the total value of the ownership or investment interests held in the hospital, or in an entity whose assets include the hospital, by physician owners or investors in the aggregate does not exceed such percentage as of the date of enactment of this subsection.

''(C) PROHIBITION ON EXPANSION OF FACILITY CAPACITY.—Except as provided in paragraph (2), the number of operating rooms, pro-

cedure rooms, or beds of the hospital at any time on or after the date of the enactment of this subsection are no greater than the number of operating rooms, procedure rooms, or beds, respectively, as of such date.

''(D) ENSURING BONA FIDE OWNERSHIP AND INVESTMENT.—

''(i) Any ownership or investment interests that the hospital offers to a physician are not offered on more favorable terms than the terms offered to a person who is not in a position to refer patients or otherwise generate business for the hospital.

''(ii) The hospital (or any investors in the hospital) does not directly or indirectly provide loans or financing for any physician owner or investor in the hospital.

''(iii) The hospital (or any investors in the hospital) does not directly or indirectly guarantee a loan, make a payment toward a loan, or otherwise subsidize a loan, for any physician owner or investor or group of physician owners or investors that is re-

lated to acquiring any ownership or investment interest in the hospital.

''(iv) Ownership or investment returns are distributed to each owner or investor in the hospital in an amount that is directly proportional to the ownership or investment interest of such owner or investor in the hospital.

''(v) The investment interest of the owner or investor is directly proportional to the owner's or investor's capital contributions made at the time the ownership or investment interest is obtained.

''(vi) Physician owners and investors do not receive, directly or indirectly, any guaranteed receipt of or right to purchase other business interests related to the hospital, including the purchase or lease of any property under the control of other owners or investors in the hospital or located near the premises of the hospital.

''(vii) The hospital does not offer a physician owner or investor the opportunity to purchase or lease any property under the control of the hospital or any

other owner or investor in the hospital on more favorable terms than the terms offered to a person that is not a physician owner or investor.

''(viii) The hospital does not condition any physician ownership or investment interests either directly or indirectly on the physician owner or investor making or influencing referrals to the hospital or otherwise generating business for the hospital.

''(E) PATIENT SAFETY.—In the case of a hospital that does not offer emergency services, the hospital has the capacity to—

''(i) provide assessment and initial treatment for medical emergencies; and

''(ii) if the hospital lacks additional capabilities required to treat the emergency involved, refer and transfer the patient with the medical emergency to a hospital with the required capability.

''(F) LIMITATION ON APPLICATION TO CERTAIN CONVERTED FACILITIES.—The hospital was not converted from an ambulatory surgical center to a hospital on or after the date of enactment of this subsection.

''(2) EXCEPTION TO PROHIBITION ON EXPANSION OF FACILITY CAPACITY.—

''(A) PROCESS.—

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

''(ii) OPPORTUNITY FOR COMMUNITY INPUT.—The process under clause (i) shall provide persons and entities in the community in which the hospital applying for an exception is located with the opportunity to provide input with respect to the application.

''(iii) TIMING FOR IMPLEMENTATION.—The Secretary shall implement the process under clause (i) on the date that is one month after the promulgation of regulations described in clause (iv).

''(iv) REGULATIONS.—Not later than the first day of the month beginning 18 months after the date of the enactment of this subsection, the Secretary shall promulgate regulations to carry out the process

under clause (i). The Secretary may issue such regulations as interim final regulations.

''(B) FREQUENCY.—The process described in subparagraph (A) shall permit a hospital to apply for an exception up to once every 2 years.

''(C) PERMITTED INCREASE.—

''(i) IN GENERAL.—Subject to clause (ii) and subparagraph (D), a hospital granted an exception under the process described in subparagraph (A) may increase the number of operating rooms, procedure rooms, or beds of the hospital above the baseline number of operating rooms, procedure rooms, or beds, respectively, of the hospital (or, if the hospital has been granted a previous exception under this paragraph, above the number of operating rooms, procedure rooms, or beds, respectively, of the hospital after the application of the most recent increase under such an exception).

''(ii) 100 PERCENT INCREASE LIMITATION.—The Secretary shall not permit an increase in the number of operating rooms,

procedure rooms, or beds of a hospital under clause (i) to the extent such increase would result in the number of operating rooms, procedure rooms, or beds of the hospital exceeding 200 percent of the baseline number of operating rooms, procedure rooms, or beds of the hospital.

''(iii) BASELINE NUMBER OF OPERATING ROOMS, PROCEDURE ROOMS, OR BEDS.—In this paragraph, the term 'baseline number of operating rooms, procedure rooms, or beds' means the number of operating rooms, procedure rooms, or beds of a hospital as of the date of enactment of this subsection.

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

''(E) CONDITIONS FOR APPROVAL OF AN INCREASE IN FACILITY CAPACITY.—The Secretary may grant an exception under the proc-

ess described in subparagraph (A) only to a hospital—

''(i) that is located in a county in which the percentage increase in the population during the most recent 5-year period for which data are available is estimated to be at least 150 percent of the percentage increase in the population growth of the State in which the hospital is located during that period, as estimated by Bureau of the Census and available to the Secretary;

''(ii) whose annual percent of total inpatient admissions that represent inpatient admissions under the program under title XIX is estimated to be equal to or greater than the average percent with respect to such admissions for all hospitals located in the county in which the hospital is located;

''(iii) that does not discriminate against beneficiaries of Federal health care programs and does not permit physicians practicing at the hospital to discriminate against such beneficiaries;

''(iv) that is located in a State in which the average bed capacity in the

State is estimated to be less than the national average bed capacity;

''(v) that has an average bed occupancy rate that is estimated to be greater than the average bed occupancy rate in the State in which the hospital is located; and

''(vi) that meets other conditions as determined by the Secretary.

''(F) PROCEDURE ROOMS.—In this subsection, the term 'procedure rooms' includes rooms in which catheterizations, angiographies, angiograms, and endoscopies are furnished, but such term shall not include emergency rooms or departments (except for rooms in which catheterizations, angiographies, angiograms, and endoscopies are furnished).

''(G) PUBLICATION OF FINAL DECISIONS.—Not later than 120 days after receiving a complete application under this paragraph, the Secretary shall publish on the public Internet website of the Centers for Medicare & Medicaid Services the final decision with respect to such application.

''(H) LIMITATION ON REVIEW.—There shall be no administrative or judicial review

under section 1869, section 1878, or otherwise of the exception process under this paragraph, including the establishment of such process, and any determination made under such process.

''(3) PHYSICIAN OWNER OR INVESTOR DEFINED.—For purposes of this subsection and subsection (f)(2), the term 'physician owner or investor' means a physician (or an immediate family member of such physician) with a direct or an indirect ownership or investment interest in the hospital.

''(4) PATIENT SAFETY REQUIREMENT.—In the case of a hospital to which the requirements of paragraph (1) apply, insofar as the hospital admits a patient and does not have any physician available on the premises 24 hours per day, 7 days per week, before admitting the patient—

''(A) the hospital shall disclose such fact to the patient; and

''(B) following such disclosure, the hospital shall receive from the patient a signed acknowledgment that the patient understands such fact.

''(5) CLARIFICATION.—Nothing in this subsection shall be construed as preventing the Secretary from terminating a hospital's provider agree-

ment if the hospital is not in compliance with regulations pursuant to section 1866.''.

(b) VERIFYING COMPLIANCE.—The Secretary of Health and Human Services shall establish policies and procedures to verify compliance with the requirements described in subsections (i)(1) and (i)(4) of section 1877 of the Social Security Act, as added by subsection (a)(5). The Secretary may use unannounced site reviews of hospitals and audits to verify compliance with such requirements.

(c) IMPLEMENTATION.—

(1) FUNDING.—For purposes of carrying out the amendments made by subsection (a) and the provisions of subsection (b), in addition to funds otherwise available, out of any funds in the Treasury not otherwise appropriated there are appropriated to the Secretary of Health and Human Services for the Centers for Medicare & Medicaid Services Program Management Account $5,000,000 for each fiscal year beginning with fiscal year 2010. Amounts appropriated under this paragraph for a fiscal year shall be available until expended.

(2) ADMINISTRATION.—Chapter 35 of title 44, United States Code, shall not apply to the amend-

ments made by subsection (a) and the provisions of subsection (b).

SEC. 1157. INSTITUTE OF MEDICINE STUDY OF GEOGRAPHIC ADJUSTMENT FACTORS UNDER MEDICARE.

(a) IN GENERAL.—The Secretary of Health and Human Services shall enter into a contract with the Institute of Medicine of the National Academy of Science to conduct a comprehensive empirical study, and provide recommendations as appropriate, on the accuracy of the geographic adjustment factors established under sections 1848(e) and 1886(d)(3)(E) of the Social Security Act (42 U.S.C. 1395w–4(e), 1395ww(d)(3)(E)).

(b) MATTERS INCLUDED.—Such study shall include an evaluation and assessment of the following with respect to such adjustment factors:

(1) Empirical validity of the adjustment factors.

(2) Methodology used to determine the adjustment factors.

(3) Measures used for the adjustment factors, taking into account—

(A) timeliness of data and frequency of revisions to such data;

(B) sources of data and the degree to which such data are representative of costs; and

(C) operational costs of providers who participate in Medicare.

(c) EVALUATION.—Such study shall, within the context of the United States health care marketplace, evaluate and consider the following:

(1) The effect of the adjustment factors on the level and distribution of the health care workforce and resources, including—

(A) recruitment and retention that takes into account workforce mobility between urban and rural areas;

(B) ability of hospitals and other facilities to maintain an adequate and skilled workforce; and

(C) patient access to providers and needed medical technologies.

(2) The effect of the adjustment factors on population health and quality of care.

(3) The effect of the adjustment factors on the ability of providers to furnish efficient, high value care.

(d) REPORT.—The contract under subsection (a) shall provide for the Institute of Medicine to submit, not later than 1 year after the date of the enactment of this Act, to the Secretary and the Congress a report containing

results and recommendations of the study conducted under this section.

(e) FUNDING.—There are authorized to be appropriated to carry out this section such sums as may be necessary.

SEC. 1158. REVISION OF MEDICARE PAYMENT SYSTEMS TO ADDRESS GEOGRAPHIC INEQUITIES.

(a) REVISION OF MEDICARE PAYMENT SYSTEMS.—Taking into account the recommendations described in the report under section 1157, and notwithstanding the geographic adjustments that would otherwise apply under section 1848(e) and section 1886(d)(3)(E) of the Social Security Act (42 U.S.C. 1395w–4(e), 1395ww(d)(3)(E)), the Secretary of Health and Human Services shall include in proposed rules applicable to the rulemaking cycle for payment systems for physicians' services and inpatient hospital services under sections 1848 and section 1886(d) of such Act, respectively, proposals (as the Secretary determines to be appropriate) to revise the geographic adjustment factors used in such systems. Such proposals' rules shall be contained in the next rulemaking cycle following the submission to the Secretary of the report described in section 1157.

(b) PAYMENT ADJUSTMENTS.—

(1) FUNDING FOR IMPROVEMENTS.—For years before 2014, the Secretary shall ensure that the additional expenditures resulting from the implementation of the provisions of this section, as estimated by the Secretary, do not exceed $8,000,000,000, and do not exceed half of such amount in any payment year.

(2) HOLD HARMLESS.—In carrying out this subsection—

(A) for payment years before 2014, the Secretary shall not reduce the geographic adjustment below the factor that applied for such payment system in the payment year before such changes; and

(B) for payment years beginning with 2014, the Secretary shall implement the geographic adjustment in a manner that does not result in any net change in aggregate expenditures under title XVIII of the Social Security Act from the amount of such expenditures that the Secretary estimates would have occurred if no geographic adjustment had occurred under this section.

(c) MEDICARE IMPROVEMENT FUND.—

(1) Amounts in the Medicare Improvement Fund under section 1898 of the Social Security Act,

as amended by paragraph (2), 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.

(2) Section 1898(b) of the Social Security Act (42 U.S.C. 1395iii(b)) is amended—

(A) by amending paragraph (1)(A) to read as follows:

''(A) the period beginning with fiscal year 2011 and ending with fiscal year 2019, $8,000,000,000; and''; and

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

''(5) ADJUSTMENT FOR UNDERFUNDING.—For fiscal year 2014 or a subsequent fiscal year specified by the Secretary, the amount available to the fund under subsection (a) shall be increased by the Secretary's estimate of the amount (based on data on actual expenditures) by which—

''(A) the additional expenditures resulting from the implementation of subsection (a) of section 1158 of the Affordable Health Care for

America Act for the period before fiscal year 2014, is less than

''(B) the maximum amount of funds available under subsection (a) of such section for funding for such expenditures.''.

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 (in this section and the succeeding section referred to as the ''Secretary'') shall enter into an agreement with the Institute of Medicine of the National Academies (referred to in this section as the ''Institute'') to conduct a study on geographic variation and growth in volume and intensity of services in per capita health care spending among the Medicare, Medicaid, privately insured and uninsured populations. Such study may draw on recent relevant reports of the Institute and shall include each of the following:

(1) An evaluation of the extent and range of such variation using various units of geographic measurement, including micro areas within larger areas.

(2) An evaluation of the extent to which geographic variation can be attributed to differences in input prices; health status; practice patterns; access to medical services; supply of medical services; socioeconomic factors, including race, ethnicity, gender, age, income and educational status; and provider and payer organizational models.

(3) An evaluation of the extent to which variations in spending are correlated with patient access to care, insurance status, distribution of health care resources, health care outcomes, and consensus-based measures of health care quality.

(4) An evaluation of the extent to which variation can be attributed to physician and practitioner discretion in making treatment decisions, and the degree to which discretionary treatment decisions are made that could be characterized as different from the best available medical evidence.

(5) An evaluation of the extent to which variation can be attributed to patient preferences and patient compliance with treatment protocols.

(6) An assessment of the degree to which variation cannot be explained by empirical evidence.

(7) For Medicare beneficiaries, An evaluation of the extent to which variations in spending are cor-

related with insurance status prior to enrollment in the Medicare program under title XVIII of the Social Security Act, and institutionalization status; whether beneficiaries are dually eligible for the Medicare program and Medicaid under title XIX of such Act; and whether beneficiaries are enrolled in fee-for-service Medicare or Medicare Advantage.

(8) An evaluation of such other factors as the Institute deems appropriate.

The Institute shall conduct public hearings and provide an opportunity for comments prior to completion of the reports under subsection (e).

(b) RECOMMENDATIONS.—Taking into account the findings under subsection (a) and the changes to the payment systems made by this Act, the Institute shall recommend changes to payment for items and services under parts A and B of title XVIII of the Social Security Act, for addressing variation in Medicare per capita spending for items and services (not including add-ons for graduate medical education, disproportionate share payments, and health information technology, as specified in sections 1886(d)(5)(F), 1886(d)(5)(B), 1886(h), 1848(o), and 1886(n), respectively, of such Act) by promoting high-value care (as defined in subsection (f)), with particular attention to high-volume, high-cost conditions. In making

such recommendations, the Institute shall consider each of the following:

(1) Measurement and reporting on quality and population health.

(2) Reducing fragmented and duplicative care.

(3) Promoting the practice of evidence-based medicine.

(4) Empowering patients to make value-based care decisions.

(5) Leveraging the use of health information technology.

(6) The role of financial and other incentives affecting provision of care.

(7) Variation in input costs.

(8) The characteristics of the patient population, including socio-economic factors (including race, ethnicity, gender, age, income and educational status), and whether the beneficiaries are dually eligible for the Medicare program under title XVIII of the Social Security Act and Medicaid under title XIX of such Act.

(9) Other topics the Institute deems appropriate.

In making such recommendations, the Institute shall consider an appropriate phase-in that takes into account the

impact of payment changes on providers and facilities and preserves access to care for Medicare beneficiaries.

(c) SPECIFIC CONSIDERATIONS.—In making the recommendations under subsection (b), the Institute shall specifically address whether payment systems under title XVIII of the Social Security Act for physicians and hospitals should be further modified to incentivize high-value care. In so doing, the Institute shall consider the adoption of a value index based on a composite of appropriate measures of quality and cost that would adjust provider payments on a regional or provider-level basis. If the Institute finds that application of such a value index would significantly incentivize providers to furnish high-value care, it shall make specific recommendations on how such an index would be designed and implemented. In so doing, it should identify specific measures of quality and cost appropriate for use in such an index, and include a thorough analysis (including on a geographic basis) of how payments and spending under such title would be affected by such an index.

(d) ADDITIONAL CONSIDERATIONS.—The Institute shall consider the experience of governmental and community-based programs that promote high-value care.

(e) REPORTS.—

(1) Not later than April 15, 2011, the Institute shall submit to the Secretary and each House of Congress a report containing findings and recommendations of the study conducted under this section.

(2) Following submission of the report under paragraph (1), the Institute shall use the data collected and analyzed in this section to issue a subsequent report, or series of reports, on how best to address geographic variation or efforts to promote high-value care for items and services reimbursed by private insurance or other programs. Such reports shall include a comparison to the Institute's findings and recommendations regarding the Medicare program. Such reports, and any recommendations, would not be subject to the procedures outlined in section 1160.

(f) HIGH-VALUE CARE DEFINED.—For purposes of this section, the term ''high-value care'' means the efficient delivery of high quality, evidence-based, patient-centered care.

(g) APPROPRIATIONS.—There is appropriated from amounts in the general fund of the Treasury not otherwise appropriated $10,000,000 to carry out this section. Such sums are authorized to remain available until expended.

SEC. 1160. IMPLEMENTATION, AND CONGRESSIONAL REVIEW, OF PROPOSAL TO REVISE MEDICARE PAYMENTS TO PROMOTE HIGH VALUE HEALTH CARE.

(a) PREPARATION AND SUBMISSION OF IMPLEMENTATION PLANS.—

(1) FINAL IMPLEMENTATION PLAN.—Not later than 240 days after the date of receipt by the Secretary and each House of Congress of the report under section 1159(e)(1), the Secretary shall submit to each House of Congress a final implementation plan describing proposed changes to payment for items and services under parts A and B of title XVIII of the Social Security Act (which may include payment for inpatient and outpatient hospital services for services furnished in PPS and PPS-exempt hospitals, physicians' services, dialysis facility services, skilled nursing facility services, home health services, hospice care, clinical laboratory services, durable medical equipment, and other items and services, but which shall exclude add-on payments for graduate medical education, disproportionate share payments, and health information technology, as specified in sections 1886(d)(5)(F), 1886(d)(5)(B), 1886(h), 1848(o), and 1886(n), respectively, of the Social Security Act) taking into

consideration, as appropriate, the recommendations of the report submitted under section 1159(e)(1) and the changes to the payment systems made by this Act. To the extent such implementation plan requires a substantial change to the payment system, it shall include a transition phase-in that takes into consideration possible disruption to provider participation in the Medicare program under title XVIII of the Social Security Act and preserves access to care for Medicare beneficiaries.

(2) PRELIMINARY IMPLEMENTATION PLAN.—Not later than 90 days after the date the Institute of Medicine submits to each House of Congress the report under section 1159(e)(1), the Secretary shall submit to each House of Congress a preliminary version of the implementation plan provided for under paragraph (1)(A).

(3) NO INCREASE IN BUDGET EXPENDITURES.—The Secretary shall include with the submission of the final implementation plan under paragraph (1) a certification by the Chief Actuary of the Centers for Medicare & Medicaid Services that over the initial 10-year period in which the plan is implemented, the aggregate level of net expenditures under the Medicare program under title XVIII of

the Social Security Act will not exceed the aggregate level of such expenditures that would have occurred if the plan were not implemented.

(4) WAIVERS REQUIRED.—To the extent the final implementation plan under paragraph (1) proposes changes that are not otherwise permitted under title XVIII of the Social Security Act, the Secretary shall specify in the plan the specific waivers required under such title to implement such changes. Except as provided in subsection (c), the Secretary is authorized to waive the requirements so specified in order to implement such changes.

(5) ASSESSMENT OF IMPACT.—In addition, both the preliminary and final implementation plans under this subsection shall include a detailed assessment of the effects of the proposed payment changes by provider or supplier type and State relative to the payments that would otherwise apply.

(b) REVIEW BY MEDPAC AND GAO.—Not later than 45 days after the date the preliminary implementation plan is received by each House of Congress under subsection (a)(2), the Medicare Payment Advisory Committee and the Comptroller General of the United States shall each evaluate such plan and submit to each House of Congress a report containing its analysis and recommenda-

tions regarding implementation of the plan, including an analysis of the effects of the proposed changes in the plan on payments and projected spending.

(c) IMPLEMENTATION.—

(1) IN GENERAL.—The Secretary shall include, in applicable proposed rules for the next rulemaking cycle beginning after the Congressional action deadline, appropriate proposals to revise payments under title XVIII of the Social Security Act in accordance with the final implementation plan submitted under subsection (a)(1), and the waivers specified in subsection (a)(4) to the extent required to carry out such plan are effective, unless a joint resolution (described in subsection (d)(5)(A)) with respect to such plan is enacted by not later than such deadline. If such a joint resolution is enacted, the Secretary is not authorized to implement such plan and the waiver authority provided under subsection (a)(4) shall no longer be effective.

(2) CONGRESSIONAL ACTION DEADLINE.—For purposes of this section, the term ''Congressional action deadline'' means, with respect to a final implementation plan under subsection (a)(1), May 31, 2012, or, if later, the date that is 145 days after the

date of receipt of such plan by each House of Congress under subsection (a).

(d) CONGRESSIONAL PROCEDURES.—

(1) INTRODUCTION.—On the day on which the final implementation plan is received by the House of Representatives and the Senate under subsection (a), a joint resolution specified in paragraph (5)(A) shall be introduced in the House of Representatives by the majority leader and minority leader of the House of Representatives and in the Senate by the majority leader and minority leader of the Senate. If either House is not in session on the day on which such a plan is received, the joint resolution with respect to such plan shall be introduced in that House, as provided in the preceding sentence, on the first day thereafter on which that House is in session.

(2) CONSIDERATION IN THE HOUSE OF REPRESENTATIVES.—

(A) REPORTING AND DISCHARGE.—Any committee of the House of Representatives to which a joint resolution introduced under paragraph (1) is referred shall report such joint resolution to the House not later than 50 legislative days after the applicable date of introduction of the joint resolution. If a committee fails

to report such joint resolution within that period, a motion to discharge the committee from further consideration of the joint resolution shall be in order. Such a motion shall be in order only at a time designated by the Speaker in the legislative schedule within two legislative days after the day on which the proponent announces an intention to offer the motion. Notice may not be given on an anticipatory basis. Such a motion shall not be in order after the last committee authorized to consider the joint resolution reports it to the House or after the House has disposed of a motion to discharge the joint resolution. The previous question shall be considered as ordered on the motion to its adoption without intervening motion except 20 minutes of debate equally divided and controlled by the proponent and an opponent. A motion to reconsider the vote by which the motion is disposed of shall not be in order.

(B) PROCEEDING TO CONSIDERATION.—After each committee authorized to consider a joint resolution reports such joint resolution to the House of Representatives or has been discharged from its consideration, a motion to pro-

ceed to consider such joint resolution shall be in order. Such a motion shall be in order only at a time designated by the Speaker in the legislative schedule within two legislative days after the day on which the proponent announces an intention to offer the motion. Notice may not be given on an anticipatory basis. Such a motion shall not be in order after the House of Representatives has disposed of a motion to proceed on the joint resolution. The previous question shall be considered as ordered on the motion to its adoption without intervening motion. A motion to reconsider the vote by which the motion is disposed of shall not be in order.

(C) CONSIDERATION.—The joint resolution shall be considered in the House and shall be considered as read. All points of order against a joint resolution and against its consideration are waived. The previous question shall be considered as ordered on the joint resolution to its passage without intervening motion except two hours of debate equally divided and controlled by the proponent and an opponent. A motion to reconsider the vote on passage of a joint resolution shall not be in order.

(3) CONSIDERATION IN THE SENATE.—

(A) REPORTING AND DISCHARGE.—Any committee of the Senate to which a joint resolution introduced under paragraph (1) is referred shall report such joint resolution to the Senate within 50 legislative days. If a committee fails to report such joint resolution at the close of the 15th legislative day after its receipt by the Senate, such committee shall be automatically discharged from further consideration of such joint resolution and such joint resolution or joint resolutions shall be placed on the calendar. A vote on final passage of such joint resolution shall be taken in the Senate on or before the close of the second legislative day after such joint resolution is reported by the committee or committees of the Senate to which it was referred, or after such committee or committees have been discharged from further consideration of such joint resolution.

(B) PROCEEDING TO CONSIDERATION.—A motion in the Senate to proceed to the consideration of a joint resolution shall be privileged and not debatable. An amendment to such a motion shall not be in order, nor shall it be in

order to move to reconsider the vote by which such a motion is agreed to or disagreed to.

(C) CONSIDERATION.—

(i) Debate in the Senate on a joint resolution, and all debatable motions and appeals in connection therewith, shall be limited to not more than 20 hours. The time shall be equally divided between, and controlled by, the majority leader and the minority leader or their designees.

(ii) Debate in the Senate on any debatable motion or appeal in connection with a joint resolution shall be limited to not more than 1 hour, to be equally divided between, and controlled by, the mover and the manager of the resolution, except that in the event the manager of the joint resolution is in favor of any such motion or appeal, the time in opposition thereto shall be controlled by the minority leader or a designee. Such leaders, or either of them, may, from time under their control on the passage of a joint resolution, allot additional time to any Senator

during the consideration of any debatable motion or appeal.

(iii) A motion in the Senate to further limit debate is not debatable. A motion to recommit a joint resolution is not in order.

(4) RULES RELATING TO SENATE AND HOUSE OF REPRESENTATIVES.—

(A) COORDINATION WITH ACTION BY OTHER HOUSE.—If, before the passage by one House of a joint resolution of that House, that House receives from the other House a joint resolution, then the following procedures shall apply:

(i) The joint resolution of the other House shall not be referred to a committee.

(ii) With respect to the joint resolution of the House receiving the resolution, the procedure in that House shall be the same as if no such joint resolution had been received from the other House; but the vote on passage shall be on the joint resolution of the other House.

(B) TREATMENT OF COMPANION MEASURES.—If, following passage of a joint resolu-

tion in the Senate, the Senate then receives the companion measure from the House of Representatives, the companion measure shall not be debatable.

(C) RULES OF HOUSE OF REPRESENTATIVES AND SENATE.—This paragraph and the preceding paragraphs are enacted by Congress—

(i) as an exercise of the rulemaking power of the Senate and House of Representatives, respectively, and as such it is deemed a part of the rules of each House, respectively, but applicable only with respect to the procedure to be followed in that House in the case of a joint resolution, and it supersedes other rules only to the extent that it is inconsistent with such rules; and

(ii) with full recognition of the constitutional right of either House to change the rules (so far as relating to the procedure of that House) at any time, in the same manner, and to the same extent as in the case of any other rule of that House.

(5) DEFINITIONS.—In this section:

(A) JOINT RESOLUTION.—The term ''joint resolution'' means only a joint resolution—

(i) which does not have a preamble;

(ii) the title of which is as follows: ''Joint resolution disapproving a Medicare final implementation plan of the Secretary of Health and Human Services submitted under section 1160(a) of the Affordable Health Care for America Act''; and

(iii) the sole matter after the resolving clause of which is as follows: ''That the Congress disapproves the final implementation plan of the Secretary of Health and Human Services transmitted to the Congress on————————.'', the blank space being filled with the appropriate date.

(B) LEGISLATIVE DAY.—The term ''legislative day'' means any calendar day excluding any day on which that House was not in session.

(6) BUDGETARY TREATMENT.—For the purposes of consideration of a joint resolution, the Chairmen of the House of Representatives and Senate Committees on the Budget shall exclude from the evaluation of the budgetary effects of the meas-

ure, any such effects that are directly attributable to disapproving a Medicare final implementation plan of the Secretary submitted under subsection (a).

Subtitle D—Medicare Advantage Reforms

PART 1—PAYMENT AND ADMINISTRATION

SEC. 1161. PHASE-IN OF PAYMENT BASED ON FEE-FOR-SERVICE COSTS; QUALITY BONUS PAYMENTS.

(a) PHASE-IN OF PAYMENT BASED ON FEE-FOR-SERVICE COSTS.—Section 1853 of the Social Security Act (42 U.S.C. 1395w–23) is amended—

(1) in subsection (j)(1)(A)—

(A) by striking ''beginning with 2007'' and inserting ''for 2007, 2008, 2009, and 2010''; and

(B) by inserting after ''(k)(1)'' the following: '', or, beginning with 2011, 1/12 of the blended benchmark amount determined under subsection (n)(1)''; and

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

''(n) DETERMINATION OF BLENDED BENCHMARK AMOUNT.—

''(1) IN GENERAL.—For purposes of subsection (j), subject to paragraphs (3) and (4), the term 'blended benchmark amount' means for an area—

''(A) for 2011 the sum of—

''(i) ⅔ of the applicable amount (as defined in subsection (k)) for the area and year; and

''(ii) ⅓ of the amount specified in paragraph (2) for the area and year;

''(B) for 2012 the sum of—

''(i) ⅓ of the applicable amount for the area and year; and

''(ii) ⅔ of the amount specified in paragraph (2) for the area and year; and

''(C) for a subsequent year the amount specified in paragraph (2) for the area and year.

''(2) SPECIFIED AMOUNT.—The amount specified in this paragraph for an area and year is the amount specified in subsection (c)(1)(D)(i) for the area and year adjusted (in a manner specified by the Secretary) to take into account the phase-out in the indirect costs of medical education from capitation rates described in subsection (k)(4).

''(3) FEE-FOR-SERVICE PAYMENT FLOOR.—In no case shall the blended benchmark amount for an area and year be less than the amount specified in paragraph (2).

''(4) EXCEPTION FOR PACE PLANS.—This subsection shall not apply to payments to a PACE program under section 1894.''.

(b) QUALITY BONUS PAYMENTS.—Section 1853 of the Social Security Act (42 U.S.C. 1395w-23), as amended by subsection (a), is amended—

(1) in subsection (j), by inserting ''subject to subsection (o),'' after ''For purposes of this part,''; and

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

''(o) QUALITY BASED PAYMENT ADJUSTMENT.—

''(1) IN GENERAL.—In the case of a qualifying plan in a qualifying county with respect to a year beginning with 2011, the blended benchmark amount under subsection (n)(1) shall be increased—

''(A) for 2011, by 1.5 percent;

''(B) for 2012, by 3.0 percent; and

''(C) for a subsequent year, by 5.0 percent.

''(2) QUALIFYING PLAN AND QUALIFYING COUNTY DEFINED.—For purposes of this subsection:

''(A) QUALIFYING PLAN.—The term 'qualifying plan' means, for a year and subject to paragraph (4), a plan that, in a preceding year specified by the Secretary, had a quality ranking (based on the quality ranking system established by the Centers for Medicare & Medicaid Services for Medicare Advantage plans) of 4 stars or higher.

''(B) QUALIFYING COUNTY.—The term 'qualifying county' means, for a year, a county—

''(i) that ranked within the lowest third of counties in the amount specified in subsection (n)(2) for a year specified by the Secretary; and

''(ii) for which, as of June of a year specified by the Secretary, of the Medicare Advantage eligible individuals residing in the county at least 20 percent of such individuals were enrolled in Medicare Advantage plans.

''(3) DETERMINATIONS OF QUALITY.—

''(A) QUALITY PERFORMANCE.—The Secretary shall provide for the computation of a

quality performance score for each Medicare Advantage plan to be applied for each year.

''(B) COMPUTATION OF SCORE.—

''(i) QUALITY PERFORMANCE SORE.—For years before a year specified by the Secretary, the quality performance score for a Medicare Advantage plan shall be computed based on a blend (as designated by the Secretary) of the plan's performance on—

''(I) HEDIS effectiveness of care quality measures;

''(II) CAHPS quality measures; and

''(III) such other measures of clinical quality as the Secretary may specify.

Such measures shall be risk-adjusted as the Secretary deems appropriate.

''(ii) ESTABLISHMENT OF OUTCOME-BASED MEASURES.—By not later than for a year specified by the Secretary, the Secretary shall implement reporting requirements for quality under this section on measures selected under clause (iii) that

reflect the outcomes of care experienced by individuals enrolled in Medicare Advantage plans (in addition to measures described in clause (i)). Such measures may include—

''(I) measures of rates of admission and readmission to a hospital;

''(II) measures of prevention quality, such as those established by the Agency for Healthcare Research and Quality (that include hospital admission rates for specified conditions);

''(III) measures of patient mortality and morbidity following surgery;

''(IV) measures of health functioning (such as limitations on activities of daily living) and survival for patients with chronic diseases;

''(V) measures of patient safety; and

''(VI) other measure of outcomes and patient quality of life as determined by the Secretary.

Such measures shall be risk-adjusted as the Secretary deems appropriate. In determining the quality measures to be used

under this clause, the Secretary shall take into consideration the recommendations of the Medicare Payment Advisory Commission in its report to Congress under section 168 of the Medicare Improvements for Patients and Providers Act of 2008 (Public Law 110–275) and shall provide preference to measures collected on and comparable to measures used in measuring quality under parts A and B.

''(iii) RULES FOR SELECTION OF MEASURES.—The Secretary shall select measures for purposes of clause (ii) consistent with the following:

''(I) The Secretary shall provide preference to clinical quality measures that have been endorsed by the entity with a contract with the Secretary under section 1890(a).

''(II) Prior to any measure being selected under this clause, the Secretary shall publish in the Federal Register such measure and provide for a period of public comment on such measure.

''(iv) TRANSITIONAL USE OF BLEND.—For payments for years specified by the Secretary, the Secretary may compute the quality performance score for a Medicare Advantage plan based on a blend of the measures specified in clause (i) and the measures described in clause (ii) and selected under clause (iii).

''(v) USE OF QUALITY OUTCOMES MEASURES.—For payments beginning with a year specified by the Secretary (beginning after the years specified for section (iv)), the preponderance of measures used under this paragraph shall be quality outcomes measures described in clause (ii) and selected under clause (iii).

''(C) REPORTING OF DATA.—Each Medicare Advantage organization shall provide for the reporting to the Secretary of quality performance data described in this paragraph (in order to determine a quality performance score under this paragraph) in such time and manner as the Secretary shall specify.

''(4) 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.

''(5) 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. 1162. AUTHORITY FOR SECRETARIAL CODING INTENSITY ADJUSTMENT AUTHORITY.

Section 1853(a)(1)(C)(ii) of the Social Security Act (42 U.S.C. 1395w–23(a)(1)(C)(ii) is amended—

(1) in the matter before subclause (I), by striking ''through 2010'' and inserting ''and each subsequent year''; and

(2) in subclause (II)—

(A) by inserting ''periodically'' before ''conduct an analysis'';

(B) by inserting ''on a timely basis'' after ''are incorporated''; and

(C) by striking ''only for 2008, 2009, and 2010'' and inserting ''for 2008 and subsequent years''.

SEC. 1163. SIMPLIFICATION OF ANNUAL BENEFICIARY ELECTION PERIODS.

(a) 2 WEEK PROCESSING PERIOD FOR ANNUAL ENROLLMENT PERIOD (AEP).—Paragraph (3)(B) of section 1851(e) of the Social Security Act (42 U.S.C. 1395w–21(e)) is amended—

(1) by striking ''and'' at the end of clause (iii);

(2) in clause (iv)—

(A) by striking ''and succeeding years'' and inserting '', 2008, 2009, and 2010''; and

(B) by striking the period at the end and inserting ''; and''; and

(3) by adding at the end the following new clause:

''(v) with respect to 2011 and succeeding years, the period beginning on November 1 and ending on December 15 of the year before such year.''.

(b) ELIMINATION OF 3-MONTH ADDITIONAL OPEN ENROLLMENT PERIOD (OEP).—Effective for plan years beginning with 2011, paragraph (2) of such section is amended by striking subparagraph (C).

SEC. 1164. EXTENSION OF REASONABLE COST CONTRACTS.

Section 1876(h)(5)(C) of the Social Security Act (42 U.S.C. 1395mm(h)(5)(C)) is amended—

(1) in clause (ii), by striking ''January 1, 2010'' and inserting ''January 1, 2012''; and

(2) in clause (iii), by striking ''the service area for the year'' and inserting ''the portion of the plan's service area for the year that is within the service area of a reasonable cost reimbursement contract''.

SEC. 1165. LIMITATION OF WAIVER AUTHORITY FOR EMPLOYER GROUP PLANS.

(a) IN GENERAL.—The first sentence of each of paragraphs (1) and (2) of section 1857(i) of the Social Security Act (42 U.S.C. 1395w–27(i)) is amended by inserting before the period at the end the following: '', but only if 90 percent of the Medicare Advantage eligible individuals enrolled under such plan reside in a county in which the MA organization offers an MA local plan''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply for plan years beginning on or after January 1, 2011, and shall not apply to plans which were in effect as of December 31, 2010.

SEC. 1166. IMPROVING RISK ADJUSTMENT FOR PAYMENTS.

(a) REPORT TO CONGRESS.—Not later than 1 year after the date of the enactment of this Act, the Secretary

of Health and Human Services shall submit to Congress a report that evaluates the adequacy of the risk adjustment system under section 1853(a)(1)(C) of the Social Security Act (42 U.S.C. 1395–23(a)(1)(C)) in predicting costs for beneficiaries with chronic or co-morbid conditions, beneficiaries dually-eligible for Medicare and Medicaid, and non-Medicaid eligible low-income beneficiaries; and the need and feasibility of including further gradations of diseases or conditions and multiple years of beneficiary data.

(b) IMPROVEMENTS TO RISK ADJUSTMENT.—Not later than January 1, 2012, the Secretary shall implement necessary improvements to the risk adjustment system under section 1853(a)(1)(C) of the Social Security Act (42 U.S.C. 1395–23(a)(1)(C)), taking into account the evaluation under subsection (a).

SEC. 1167. ELIMINATION OF MA REGIONAL PLAN STABILIZATION FUND.

(a) IN GENERAL.—Section 1858 of the Social Security Act (42 U.S.C. 1395w–27a) is amended by striking subsection (e).

(b) TRANSITION.—Any amount contained in the MA Regional Plan Stabilization Fund as of the date of the enactment of this Act shall be transferred to the Federal Supplementary Medical Insurance Trust Fund.

SEC. 1168. STUDY REGARDING THE EFFECTS OF CALCULATING MEDICARE ADVANTAGE PAYMENT RATES ON A REGIONAL AVERAGE OF MEDICARE FEE FOR SERVICE RATES.

(a) IN GENERAL.—The Administrator of the Centers for Medicare and Medicaid Services shall conduct a study to determine the potential effects of calculating Medicare Advantage payment rates on a more aggregated geographic basis (such as metropolitan statistical areas or other regional delineations) rather than using county boundaries. In conducting such study, the Administrator shall consider the effect of such alternative geographic basis on the following:

(1) The quality of care received by Medicare Advantage enrollees.

(2) The networks of Medicare Advantage plans, including any implications for providers contracting with Medicare Advantage plans.

(3) The predictability of benchmark amounts for Medicare advantage plans.

(b) CONSULTATIONS.—In conducting the study, the Administrator shall consult with the following:

(1) Experts in health care financing.

(2) Representatives of foundations and other nonprofit entities that have conducted or supported research on Medicare financing issues.

(3) Representatives from Medicare Advantage plans.

(4) Such other entities or people as determined by the Secretary.

(c) REPORT.—Not later than one year after the date of the enactment of this Act, the Administrator shall transmit a report to the Congress on the study conducted under this section. The report shall contain a detailed statement of findings and conclusions of the study, together with its recommendations for such legislation and administrative actions as the Administrator considers appropriate.

PART 2—BENEFICIARY PROTECTIONS AND ANTI-FRAUD

SEC. 1171. LIMITATION ON COST-SHARING FOR INDIVIDUAL HEALTH SERVICES.

(a) IN GENERAL.—Section 1852(a)(1) of the Social Security Act (42 U.S.C. 1395w–22(a)(1)) is amended—

(1) in subparagraph (A), by inserting before the period at the end the following: ''with cost-sharing that is no greater (and may be less) than the cost-sharing that would otherwise be imposed under such program option'';

(2) in subparagraph (B)(i), by striking ''or an actuarially equivalent level of cost-sharing as determined in this part''; and

(3) by amending clause (ii) of subparagraph (B) to read as follows:

''(ii) PERMITTING USE OF FLAT COPAYMENT OR PER DIEM RATE.—Nothing in clause (i) shall be construed as prohibiting a Medicare Advantage plan from using a flat copayment or per diem rate, in lieu of the cost-sharing that would be imposed under part A or B, so long as the amount of the cost-sharing imposed does not exceed the amount of the cost-sharing that would be imposed under the respective part if the individual were not enrolled in a plan under this part.''.

(b) LIMITATION FOR DUAL ELIGIBLES AND QUALIFIED MEDICARE BENEFICIARIES.—Section 1852(a)(7) of such Act is amended to read as follows:

''(7) LIMITATION ON COST-SHARING FOR DUAL ELIGIBLES AND QUALIFIED MEDICARE BENEFICIARIES.—In the case of a individual who is a full-benefit dual eligible individual (as defined in section 1935(c)(6)) or a qualified medicare beneficiary (as

defined in section 1905(p)(1)) who is enrolled in a Medicare Advantage plan, the plan may not impose cost-sharing that exceeds the amount of cost-sharing that would be permitted with respect to the individual under this title and title XIX if the individual were not enrolled with such plan.''.

(c) EFFECTIVE DATES.—

(1) The amendments made by subsection (a) shall apply to plan years beginning on or after January 1, 2011.

(2) The amendments made by subsection (b) shall apply to plan years beginning on or after January 1, 2011.

SEC. 1172. CONTINUOUS OPEN ENROLLMENT FOR ENROLLEES IN PLANS WITH ENROLLMENT SUSPENSION.

Section 1851(e)(4) of the Social Security Act (42 U.S.C. 1395w(e)(4)) is amended—

(1) in subparagraph (C), by striking at the end ''or'';

(2) in subparagraph (D)—

(A) by inserting '', taking into account the health or well-being of the individual'' before the period; and

(B) by redesignating such subparagraph as subparagraph (E); and

(3) by inserting after subparagraph (C) the following new subparagraph:

''(D) the individual is enrolled in an MA plan and enrollment in the plan is suspended under paragraph (2)(B) or (3)(C) of section 1857(g) because of a failure of the plan to meet applicable requirements; or''.

SEC. 1173. INFORMATION FOR BENEFICIARIES ON MA PLAN ADMINISTRATIVE COSTS.

(a) DISCLOSURE OF MEDICAL LOSS RATIOS AND OTHER EXPENSE DATA.—Section 1851 of the Social Security Act (42 U.S.C. 1395w–21), as previously amended by this subtitle, is amended by adding at the end the following new subsection:

''(p) PUBLICATION OF MEDICAL LOSS RATIOS AND OTHER COST-RELATED INFORMATION.—

''(1) IN GENERAL.—The Secretary shall publish, not later than November 1 of each year (beginning with 2011), for each MA plan contract, the medical loss ratio of the plan in the previous year.

''(2) SUBMISSION OF DATA.—

''(A) IN GENERAL.—Each MA organization shall submit to the Secretary, in a form and

manner specified by the Secretary, data necessary for the Secretary to publish the medical loss ratio on a timely basis.

''(B) DATA FOR 2010 AND 2011.—The data submitted under subparagraph (A) for 2010 and for 2011 shall be consistent in content with the data reported as part of the MA plan bid in June 2009 for 2010.

''(C) USE OF STANDARDIZED ELEMENTS AND DEFINITIONS.—The data to be submitted under subparagraph (A) relating to medical loss ratio for a year, beginning with 2012, shall be submitted based on the standardized elements and definitions developed under paragraph (3).

''(3) DEVELOPMENT OF DATA REPORTING STANDARDS.—

''(A) IN GENERAL.—The Secretary shall develop and implement standardized data elements and definitions for reporting under this subsection, for contract years beginning with 2012, of data necessary for the calculation of the medical loss ratio for MA plans. Not later than December 31, 2010, the Secretary shall publish a report describing the elements and definitions so developed.

''(B) CONSULTATION.—The Secretary shall consult with the Health Choices Commissioner, representatives of MA organizations, experts on health plan accounting systems, and representatives of the National Association of Insurance Commissioners, in the development of such data elements and definitions.

''(4) MEDICAL LOSS RATIO TO BE DEFINED.—For purposes of this part, the term 'medical loss ratio' has the meaning given such term by the Secretary, taking into account the meaning given such term by the Health Choices Commissioner under section 116 of the Affordable Health Care for America Act.''.

(b) MINIMUM MEDICAL LOSS RATIO.—Section 1857(e) of the Social Security Act (42 U.S.C. 1395w–27(e)) is amended by adding at the end the following new paragraph:

''(4) REQUIREMENT FOR MINIMUM MEDICAL LOSS RATIO.—If the Secretary determines for a contract year (beginning with 2014) that an MA plan has failed to have a medical loss ratio (as defined in section 1851(p)(4)) of at least .85—

''(A) the Secretary shall require the Medicare Advantage organization offering the plan

to give enrollees a rebate (in the second succeeding contract year) of premiums under this part (or part B or part D, if applicable) by such amount as would provide for a benefits ratio of at least .85;

''(B) for 3 consecutive contract years, the Secretary shall not permit the enrollment of new enrollees under the plan for coverage during the second succeeding contract year; and

''(C) the Secretary shall terminate the plan contract if the plan fails to have such a medical loss ratio for 5 consecutive contract years.''.

SEC. 1174. STRENGTHENING AUDIT AUTHORITY.

(a) FOR PART C PAYMENTS RISK ADJUSTMENT.—Section 1857(d)(1) of the Social Security Act (42 U.S.C. 1395w–27(d)(1)) is amended by inserting after ''section 1858(c))'' the following: '', and data submitted with respect to risk adjustment under section 1853(a)(3)''.

(b) ENFORCEMENT OF AUDITS AND DEFICIENCIES.—

(1) IN GENERAL.—Section 1857(e) of such Act, as amended by section 1173, is amended by adding at the end the following new paragraph:

''(5) ENFORCEMENT OF AUDITS AND DEFICIENCIES.—

''(A) INFORMATION IN CONTRACT.—The Secretary shall require that each contract with an MA organization under this section shall include terms that inform the organization of the provisions in subsection (d).

''(B) ENFORCEMENT AUTHORITY.—The Secretary is authorized, in connection with conducting audits and other activities under subsection (d), to take such actions, including pursuit of financial recoveries, necessary to address deficiencies identified in such audits or other activities.''.

(2) APPLICATION UNDER PART D.—For provision applying the amendment made by paragraph (1) to prescription drug plans under part D, see section 1860D–12(b)(3)(D) of the Social Security Act.

(c) EFFECTIVE DATE.—The amendments made by this section shall take effect on the date of the enactment of this Act and shall apply to audits and activities conducted for contract years beginning on or after January 1, 2011.

SEC. 1175. AUTHORITY TO DENY PLAN BIDS.

(a) IN GENERAL.—Section 1854(a)(5) of the Social Security Act (42 U.S.C. 1395w–24(a)(5)) is amended by adding at the end the following new subparagraph:

''(C) REJECTION OF BIDS.—Nothing in this section shall be construed as requiring the Secretary to accept any or every bid by an MA organization under this subsection.''.

(b) APPLICATION UNDER PART D.—Section 1860D–11(d) of such Act (42 U.S.C. 1395w–111(d)) is amended by adding at the end the following new paragraph:

''(3) REJECTION OF BIDS.—Paragraph (5)(C) of section 1854(a) shall apply with respect to bids under this section in the same manner as it applies to bids by an MA organization under such section.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to bids for contract years beginning on or after January 1, 2011.

SEC. 1175A. STATE AUTHORITY TO ENFORCE STANDARDIZED MARKETING REQUIREMENTS.

Section 1856(b)(3) of the Social Security Act (42 U.S.C. 1395w–26(b)(3)) is amended—

(1) by striking ''The standards'' and inserting ''(A) IN GENERAL.—The standards'' with appropriate indentation that is the same as for the subparagraph (B) added by paragraph (2); and

(2) by adding at the end the following new subparagraph:

''(B) ENFORCEMENT OF FEDERAL STANDARDS PERMITTED.—

''(i) IN GENERAL.—Subject to the subsequent provision of this subparagraph, nothing in this title shall be construed to prohibit a State from conducting a market conduct examination or from imposing civil monetary penalties, in accordance with laws and procedures of the State, against Medicare Advantage organizations, PDP sponsors, or agents or brokers of such organizations or sponsors for violations of the marketing requirements under subsections (h)(4), (h)(6), and (j) of section 1851 and section 1857(g)(1)(E).

''(ii) ADDITIONAL REMEDIES RESULTING FROM FEDERAL-STATE COOPERATION.—

''(I) STATE RECOMMENDATION.—A State may recommend to the Secretary the imposition of an intermediate sanction not described in clause (i) (such as those available under section 1857(g)) against a Medicare Advantage organization,

PDP sponsor, or agent or broker of such an organization or sponsor for a violation described in such clause.

''(II) RESPONSE TO RECOMMENDATION.—Not later than 30 days after receipt of a recommendation under subclause (I) from a State, with respect to a violation described in clause (i), the Secretary shall respond in writing to the State indicating the progress of any investigation involving such violation, whether the Secretary intends to pursue the recommendation from the State, and in the case the Secretary does not intend to pursue such recommendation, the reason for such decision.

''(iii) NON-DUPLICATION OF PENALTIES.—In the case that an action has been initiated against a Medicare Advantage organization, PDP sponsor, or agent or broker of such an organization or sponsor for a violation of a marketing requirement under subsection (h)(4), (h)(6), or (j) of section 1851 or section 1857(g)(1)(E)—

''(I) in the case such action has been initiated by the Secretary, no State may bring an action under such applicable subsection or section against such organization, sponsor, agent, or broker with respect to such violation during the pendency period of the action initiated by the Secretary and, if a penalty is imposed pursuant to such action, after such period; and

''(II) in the case such action has been initiated by a State, the Secretary may not bring an action under such applicable subsection or section against such organization, sponsor, agent, or broker with respect to such violation during the pendency period of the action initiated by the Secretary and, if a penalty is imposed pursuant to such action, after such period.

Nothing in this clause shall be construed as limiting the ability of the Secretary to impose any sanction other than a civil

monetary penalty under section 1857 against a Medicare Advantage organization, PDP sponsor, or agent or broker of such an organization or sponsor for a violation described in clause (i).

''(iv) CONSTRUCTION.—Nothing in this subparagraph shall be construed as affecting any State authority to regulate brokers described in this paragraph or any other conduct of a Medicare Advantage organization or PDP sponsor.''.

PART 3—TREATMENT OF SPECIAL NEEDS PLANS

SEC. 1176. LIMITATION ON ENROLLMENT OUTSIDE OPEN ENROLLMENT PERIOD OF INDIVIDUALS INTO CHRONIC CARE SPECIALIZED MA PLANS FOR SPECIAL NEEDS INDIVIDUALS.

Section 1859(f)(4) of the Social Security Act (42 U.S.C. 1395w–28(f)(4)) is amended by adding at the end the following new subparagraph:

''(C) The plan does not enroll an individual on or after January 1, 2011, other than—

''(i) during an annual, coordinated open enrollment period; or

''(ii) during a special election period consisting of the period for which the indi-

vidual has a chronic condition that qualifies the individual as an individual described in subsection (b)(6)(B)(iii) for such plan and ending on the date on which the individual enrolls in such a plan on the basis of such condition.

If an individual is enrolled in such a plan on the basis of a chronic condition and becomes eligible for another such plan on the basis of another chronic condition, the other plan may enroll the individual on the basis of such other chronic condition during a special enrollment period described in clause (ii). An individual is eligible to apply such clause only once on the basis of any specific chronic condition.''.

SEC. 1177. EXTENSION OF AUTHORITY OF SPECIAL NEEDS PLANS TO RESTRICT ENROLLMENT; SERVICE AREA MORATORIUM FOR CERTAIN SNPS.

(a) IN GENERAL.—Section 1859(f)(1) of the Social Security Act (42 U.S.C. 1395w–28(f)(1)) is amended by striking ''January 1, 2011'' and inserting ''January 1, 2013 (or January 1, 2016, in the case of a plan described in section 1177(b)(1) of the Affordable Health Care for America Act)''.

(b) EXTENSION OF CERTAIN PLANS.—

(1) PLANS DESCRIBED.—For purposes of Section 1859(f)(1) of the Social Security Act (42 U.S.C. 1395w-28(f)(1)), a plan described in this paragraph is a Medicare Advantage dual eligible special needs plan that—

(A) whose sponsoring Medicare Advantage organization, as of the date enactment of the Affordable Health Care for America Act, has a contract with a State Medicaid Agency that participated in the ''Demonstrations Serving Those Dually-Eligible for Medicare and Medicaid'' under the Medicare program; and

(B) that has been approved by the Centers for Medicare & Medicaid Services as a dual eligible special needs plan and that offers integrated Medicare and Medicaid services under a contract with the State Medicaid agency.

(2) ANALYSIS; REPORT.—

(A) ANALYSIS.—The Secretary of Health and Human Services shall provide, through a contract with an independent health services evaluation organization, for an analysis of the plans described in paragraph (1) with regard to the impact of such plans on cost, quality of care, patient satisfaction, and other subjects

specified by the Secretary. Such report also will identify statutory changes needed to simplify access to needed services, improve coordination of benefits and services and ensure protection for dual eligibles as appropriate.

(B) REPORT.—Not later than December 31, 2011, the Secretary shall submit to the Congress a report on the analysis under subparagraph (A) and shall include in such report such recommendations with regard to the treatment of such plans as the Secretary deems appropriate.

(c) EXTENSION OF SERVICE AREA MORATORIUM FOR CERTAIN SNPS.—Section 164(c)(2) of the Medicare Improvements for Patients and Providers Act of 2008 is amended by striking ''December 31, 2010'' and inserting ''December 31, 2012''.

SEC. 1178. EXTENSION OF MEDICARE SENIOR HOUSING PLANS.

Section 1859 of the Social Security Act (42 U.S.C. 1395w-28) is amended by adding at the end the following new subsection:

''(g) SPECIAL RULES FOR SENIOR HOUSING FACILITY PLANS.—

''(1) IN GENERAL.—Notwithstanding any other provision of this part, in the case of a Medicare Advantage senior housing facility plan described in paragraph (2) and for periods before January 1, 2013—

''(A) the service area of such plan may be limited to a senior housing facility in a geographic area;

''(B) the service area of such plan may not be expanded; and

''(C) additional senior housing facilities may not be serviced by such plan.

''(2) MEDICARE ADVANTAGE SENIOR HOUSING FACILITY PLAN DESCRIBED.—For purposes of this subsection, a Medicare Advantage senior housing facility plan is a Medicare Advantage plan that—

''(A)(i) restricts enrollment of individuals under this part to individuals who reside in a continuing care retirement community (as defined in section 1852(l)(4)(B));

''(ii) provides primary care services onsite and has a ratio of accessible providers to beneficiaries that the Secretary determines is adequate, taking into consideration the number of residents onsite, the health needs of those resi-

dents, and the accessibility of providers offsite; and

''(iii) provides transportation services for beneficiaries to providers outside of the facility; and

''(B) is offered by a Medicare Advantage organization that has offered at least 1 plan described in subparagraph (A) for at least 1 year prior to January 1, 2010, under a demonstration project established by the Secretary.''.

Subtitle E—Improvements to Medicare Part D

SEC. 1181. ELIMINATION OF COVERAGE GAP.

(a) IMMEDIATE REDUCTION IN COVERAGE GAP IN 2010.—Section 1860D–2(b) of the Social Security Act (42 U.S.C. 1395w–102(b)) is amended—

(1) in paragraph (3)(A), by striking ''paragraph (4)'' and inserting ''paragraphs (4) and (7)''; and

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

''(7) INCREASE IN INITIAL COVERAGE LIMIT IN 2010.—

''(A) IN GENERAL.—For plan years beginning during 2010, the initial coverage limit de-

scribed in paragraph (3)(B) otherwise applicable shall be increased by $500.

''(B) APPLICATION.—In applying subparagraph (A)—

''(i) except as otherwise provided in this subparagraph, there shall be no change in the premiums, bids, or any other parameters under this part or part C;

''(ii) costs that would be treated as incurred costs for purposes of applying paragraph (4) but for the application of subparagraph (A) shall continue to be treated as incurred costs;

''(iii) the Secretary shall establish procedures, which may include a reconciliation process, to fully reimburse PDP sponsors with respect to prescription drug plans and MA organizations with respect to MA–PD plans for the reduction in beneficiary cost sharing associated with the application of subparagraph (A);

''(iv) the Secretary shall develop an estimate of the additional increased costs attributable to the application of this paragraph for increased drug utilization and fi-

nancing and administrative costs and shall use such estimate to adjust payments to PDP sponsors with respect to prescription drug plans under this part and MA organizations with respect to MA–PD plans under part C; and

''(v) the Secretary shall establish procedures for retroactive reimbursement of part D eligible individuals who are covered under such a plan for costs which are incurred before the date of initial implementation of subparagraph (A) and which would be reimbursed under such a plan if such implementation occurred as of January 1, 2010.''.

(b) ADDITIONAL CLOSURE IN GAP BEGINNING IN 2011.—Section 1860D–2(b) of such Act (42 U.S.C. 1395w–102(b)) as amended by subsection (a), is further amended—

(1) in paragraph (3)(A), by striking ''and (7)'' and inserting '', (7), and (8)'' ;

(2) in paragraph (4)(B)(i), by inserting ''subject to paragraph (8)'' after ''purposes of this part''; and

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

''(8) PHASED-IN ELIMINATION OF COVERAGE GAP.—

''(A) IN GENERAL.—For each year beginning with 2011, the Secretary shall consistent with this paragraph progressively increase the initial coverage limit (described in subsection (b)(3)) and decrease the annual out-of-pocket threshold from the amounts otherwise computed until, beginning in 2019, there is a continuation of coverage from the initial coverage limit for expenditures incurred through the total amount of expenditures at which benefits are available under paragraph (4).

''(B) INCREASE IN INITIAL COVERAGE LIMIT.—

''(i) IN GENERAL.—For a year beginning with 2011, subject to clause (ii), the initial coverage limit otherwise computed without regard to this paragraph shall be increased by the cumulative ICL phase-in percentage (as defined in clause (iii) for the year) times the out-of-pocket gap

amount (as defined in subparagraph (D)) for the year.

''(ii) MAINTENANCE OF 2010 INITIAL COVERAGE LIMIT LEVEL.—If for a year the initial coverage limit otherwise computed under this paragraph would be less than the initial coverage limit applied during 2010, taking into account paragraph (7), the initial coverage limit for that year shall be such initial coverage limit as so applied during 2010.

''(iii) CUMULATIVE PHASE-IN PERCENTAGE.—

''(I) IN GENERAL.—For purposes of this paragraph, subject to subclause (II), the term 'cumulative ICL phase-in percentage' means for a year the sum of the annual ICL phase-in percentage (as defined in clause (iv)) for the year and the annual ICL phase-in percentages for each previous year beginning with 2011.

''(II) LIMITATION.—If the sum of the cumulative ICL phase-in percentage and the cumulative OPT

phase-in percentage (as defined in subparagraph (C)(iii)) for a year would otherwise exceed 100 percent, each such percentage shall be reduced in a proportional amount so the sum does not exceed 100 percent.

''(iv) ANNUAL ICL PHASE-IN PERCENTAGE.—For purposes of this paragraph, the term 'annual ICL phase-in percentage' means—

''(I) for 2011, 8.25 percent;

''(II) for 2012, 2013, and 2014, 4.5 percent;

''(III) for 2015 and 2016, 6 percent;

''(IV) for 2017, 7.5 percent;

''(V) for 2018, 8 percent; and

''(VI) for 2019, 8 percent, or such other percent as may be necessary to provide for a full continuation of coverage as described in subparagraph (A) in that year.

''(C) DECREASE IN ANNUAL OUT-OF-POCKET THRESHOLD.—

''(i) IN GENERAL.—For a year beginning with 2011, subject to clause (ii), the annual out-of-pocket threshold otherwise computed without regard to this paragraph shall be decreased by the cumulative OPT phase-in percentage (as defined in clause (iii) for the year) of the out-of-pocket gap amount for the year multiplied by 1.75.

''(ii) MAINTENANCE.—The Secretary shall adjust the annual out-of-pocket threshold for a year to the extent necessary to ensure that the sum of the initial coverage limit described in subparagraph (A) and the out-of-pocket gap amount (defined in subparagraph (D)), as determined for the year pursuant to the provisions of this paragraph for such year, does not exceed such sum that would have applied if this paragraph did not apply.

''(iii) CUMULATIVE OPT PHASE-IN PERCENTAGE.—For purposes of this paragraph, subject to subparagraph (B)(iii)(II), the term 'cumulative OPT phase-in percentage' means for a year the sum of the annual OPT phase-in percentage (as de-

fined in clause (iv)) for the year and the annual OPT phase-in percentages for each previous year beginning with 2011.

''(iv) ANNUAL OPT PHASE-IN PERCENTAGE.—For purposes of this paragraph, the term 'annual OPT phase-in percentage' means—

''(I) for 2011, 0 percent;

''(II) for 2012, 2013, and 2014, 4.5 percent;

''(III) for 2015 and 2016, 6 percent;

''(IV) for 2017, 7.5 percent; and

''(V) for 2018 and 2019, 8 percent.

''(D) OUT-OF-POCKET GAP AMOUNT.—For purposes of this paragraph, the term 'out-of-pocket gap amount' means for a year the amount by which—

''(i) the annual out-of-pocket threshold specified in paragraph (4)(B) for the year (as determined as if this paragraph did not apply), exceeds

''(ii) the sum of—

''(I) the annual deductible under paragraph (1) for the year; and

''(II) ¼ of the amount by which the initial coverage limit under paragraph (3) for the year (as determined as if this paragraph did not apply) exceeds such annual deductible.

''(E) RELATION TO AAHCA TRANSITIONAL INCREASE.—Except as otherwise specifically provided, this paragraph shall be applied as if no increase had been made in the initial coverage limit under paragraph (7).''.

(c) REQUIRING DRUG MANUFACTURERS TO PROVIDE DRUG REBATES FOR REBATE ELIGIBLE INDIVIDUALS.—

(1) IN GENERAL.—Section 1860D–2 of the Social Security Act (42 U.S.C. 1395w–102) is amended—

(A) in subsection (e)(1), in the matter before subparagraph (A), by inserting ''and subsection (f)'' after ''this subsection''; and

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

''(f) PRESCRIPTION DRUG REBATE AGREEMENT FOR REBATE ELIGIBLE INDIVIDUALS.—

''(1) REQUIREMENT.—

''(A) IN GENERAL.—For plan years beginning on or after January 1, 2011, in this part, the term 'covered part D drug' does not include any drug or biological product that is manufactured by a manufacturer that has not entered into and have in effect a rebate agreement described in paragraph (2).

''(B) 2010 PLAN YEAR REQUIREMENT.—Any drug or biological product manufactured by a manufacturer that declines to enter into a rebate agreement described in paragraph (2) for the period beginning on January 1, 2010, and ending on December 31, 2010, shall not be included as a 'covered part D drug ' for the subsequent plan year.

''(2) REBATE AGREEMENT.—A rebate agreement under this subsection shall require the manufacturer to provide to the Secretary a rebate for each rebate period (as defined in paragraph (6)(B)) ending after December 31, 2009, in the amount specified in paragraph (3) for any covered part D drug of the manufacturer dispensed after December 31, 2009, to any rebate eligible individual (as defined in paragraph (6)(A)) for which payment was made by a PDP sponsor under part D or a MA or-

ganization under part C for such period, including payments passed through the low-income and reinsurance subsidies under sections 1860D–14 and 1860D–15(b), respectively. Such rebate shall be paid by the manufacturer to the Secretary not later than 30 days after the date of receipt of the information described in section 1860D–12(b)(7), including as such section is applied under section 1857(f)(3), or 30 days after the receipt of information under subparagraph (D) of paragraph (3), as determined by the Secretary. Insofar as not inconsistent with this subsection, the Secretary shall establish terms and conditions of such agreement relating to compliance, penalties, and program evaluations, investigations, and audits that are similar to the terms and conditions for rebate agreements under paragraphs (3) and (4) of section 1927(b).

''(3) REBATE FOR REBATE ELIGIBLE MEDICARE DRUG PLAN ENROLLEES.—

''(A) IN GENERAL.—The amount of the rebate specified under this paragraph for a manufacturer for a rebate period, with respect to each dosage form and strength of any covered part D drug provided by such manufacturer

and dispensed to a rebate eligible individual, shall be equal to the product of—

''(i) the total number of units of such dosage form and strength of the drug so provided and dispensed for which payment was made by a PDP sponsor under part D or a MA organization under part C for the rebate period, including payments passed through the low-income and reinsurance subsidies under sections 1860D–14 and 1860D–15(b), respectively; and

''(ii) the amount (if any) by which—

''(I) the Medicaid rebate amount (as defined in subparagraph (B)) for such form, strength, and period, exceeds

''(II) the average Medicare drug program rebate eligible rebate amount (as defined in subparagraph (C)) for such form, strength, and period.

''(B) MEDICAID REBATE AMOUNT.—For purposes of this paragraph, the term 'Medicaid rebate amount' means, with respect to each dosage form and strength of a covered part D

drug provided by the manufacturer for a rebate period—

''(i) in the case of a single source drug or an innovator multiple source drug, the amount specified in paragraph (1)(A)(ii) of section 1927(c) plus the amount, if any, specified in paragraph (2)(A)(ii) of such section, for such form, strength, and period; or

''(ii) in the case of any other covered outpatient drug, the amount specified in paragraph (3)(A)(i) of such section for such form, strength, and period.

''(C) AVERAGE MEDICARE DRUG PROGRAM REBATE ELIGIBLE REBATE AMOUNT.—For purposes of this subsection, the term 'average Medicare drug program rebate eligible rebate amount' means, with respect to each dosage form and strength of a covered part D drug provided by a manufacturer for a rebate period, the sum, for all PDP sponsors under part D and MA organizations administering a MA–PD plan under part C, of—

''(i) the product, for each such sponsor or organization, of—

''(I) the sum of all rebates, discounts, or other price concessions (not taking into account any rebate provided under paragraph (2) for such dosage form and strength of the drug dispensed, calculated on a per-unit basis, but only to the extent that any such rebate, discount, or other price concession applies equally to drugs dispensed to rebate eligible Medicare drug plan enrollees and drugs dispensed to PDP and MA–PD enrollees who are not rebate eligible individuals; and

''(II) the number of the units of such dosage and strength of the drug dispensed during the rebate period to rebate eligible individuals enrolled in the prescription drug plans administered by the PDP sponsor or the MA–PD plans administered by the MA organization; divided by

''(ii) the total number of units of such dosage and strength of the drug dispensed during the rebate period to rebate eligible

individuals enrolled in all prescription drug plans administered by PDP sponsors and all MA–PD plans administered by MA organizations.

''(D) USE OF ESTIMATES.—The Secretary may establish a methodology for estimating the average Medicare drug program rebate eligible rebate amounts for each rebate period based on bid and utilization information under this part and may use these estimates as the basis for determining the rebates under this section. If the Secretary elects to estimate the average Medicare drug program rebate eligible rebate amounts, the Secretary shall establish a reconciliation process for adjusting manufacturer rebate payments not later than 3 months after the date that manufacturers receive the information collected under section 1860D-12(b)(7)(B).

''(4) LENGTH OF AGREEMENT.—The provisions of paragraph (4) of section 1927(b) (other than clauses (iv) and (v) of subparagraph (B)) shall apply to rebate agreements under this subsection in the same manner as such paragraph applies to a rebate agreement under such section.

''(5) OTHER TERMS AND CONDITIONS.—The Secretary shall establish other terms and conditions of the rebate agreement under this subsection, including terms and conditions related to compliance, that are consistent with this subsection.

''(6) DEFINITIONS.—In this subsection and section 1860D–12(b)(7):

''(A) REBATE ELIGIBLE INDIVIDUAL.—The term 'rebate eligible individual'—

''(i) means a full-benefit dual eligible individual (as defined in section 1935(c)(6)); and

''(ii) includes, for drugs dispensed after December 31, 2014, a subsidy eligible individual (as defined in section 1860D–14(a)(3)(A)).

''(B) REBATE PERIOD.—The term 'rebate period' has the meaning given such term in section 1927(k)(8).

''(7) WAIVER.—Chapter 35 of title 44, United States Code, shall not apply to the requirements under this subsection for the period beginning on January 1, 2010, and ending on December 31, 2010.''.

(2) REPORTING REQUIREMENT FOR THE DETERMINATION AND PAYMENT OF REBATES BY MANUFACTURES RELATED TO REBATE FOR REBATE ELIGIBLE MEDICARE DRUG PLAN ENROLLEES.—

(A) REQUIREMENTS FOR PDP SPONSORS.—Section 1860D–12(b) of the Social Security Act (42 U.S.C. 1395w–112(b)) is amended by adding at the end the following new paragraph:

''(7) REPORTING REQUIREMENT FOR THE DETERMINATION AND PAYMENT OF REBATES BY MANUFACTURERS RELATED TO REBATE FOR REBATE ELIGIBLE MEDICARE DRUG PLAN ENROLLEES.—

''(A) IN GENERAL.—For purposes of the rebate under section 1860D–2(f) for contract years beginning on or after January 1, 2011, each contract entered into with a PDP sponsor under this part with respect to a prescription drug plan shall require that the sponsor comply with subparagraphs (B) and (C).

''(B) REPORT FORM AND CONTENTS.—Not later than a date specified by the Secretary, a PDP sponsor of a prescription drug plan under this part shall report to each manufacturer—

''(i) information (by National Drug Code number) on the total number of units of each dosage, form, and strength of each drug of such manufacturer dispensed to rebate eligible Medicare drug plan enrollees under any prescription drug plan operated by the PDP sponsor during the rebate period;

''(ii) information on the price discounts, price concessions, and rebates for such drugs for such form, strength, and period;

''(iii) information on the extent to which such price discounts, price concessions, and rebates apply equally to rebate eligible Medicare drug plan enrollees and PDP enrollees who are not rebate eligible Medicare drug plan enrollees; and

''(iv) any additional information that the Secretary determines is necessary to enable the Secretary to calculate the average Medicare drug program rebate eligible rebate amount (as defined in paragraph (3)(C) of such section), and to determine the amount of the rebate required under

this section, for such form, strength, and period.

Such report shall be in a form consistent with a standard reporting format established by the Secretary.

''(C) SUBMISSION TO SECRETARY.—Each PDP sponsor shall promptly transmit a copy of the information reported under subparagraph (B) to the Secretary for the purpose of audit oversight and evaluation.

''(D) CONFIDENTIALITY OF INFORMATION.—The provisions of subparagraph (D) of section 1927(b)(3), relating to confidentiality of information, shall apply to information reported by PDP sponsors under this paragraph in the same manner that such provisions apply to information disclosed by manufacturers or wholesalers under such section, except—

''(i) that any reference to 'this section' in clause (i) of such subparagraph shall be treated as being a reference to this section;

''(ii) the reference to the Director of the Congressional Budget Office in clause (iii) of such subparagraph shall be treated

as including a reference to the Medicare Payment Advisory Commission; and

''(iii) clause (iv) of such subparagraph shall not apply.

''(E) OVERSIGHT.—Information reported under this paragraph may be used by the Inspector General of the Department of Health and Human Services for the statutorily authorized purposes of audit, investigation, and evaluations.

''(F) PENALTIES FOR FAILURE TO PROVIDE TIMELY INFORMATION AND PROVISION OF FALSE INFORMATION.—In the case of a PDP sponsor—

''(i) that fails to provide information required under subparagraph (B) on a timely basis, the sponsor is subject to a civil money penalty in the amount of $10,000 for each day in which such information has not been provided; or

''(ii) that knowingly (as defined in section 1128A(i)) provides false information under such subparagraph, the sponsor is subject to a civil money penalty in an

amount not to exceed $100,000 for each item of false information.

Such civil money penalties are in addition to other penalties as may be prescribed by law. The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under this subparagraph in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).''.

(B) APPLICATION TO MA ORGANIZATIONS.—Section 1857(f)(3) of the Social Security Act (42 U.S.C. 1395w–27(f)(3)) is amended by adding at the end the following:

''(D) REPORTING REQUIREMENT RELATED TO REBATE FOR REBATE ELIGIBLE MEDICARE DRUG PLAN ENROLLEES.—Section 1860D–12(b)(7).''.

(3) DEPOSIT OF REBATES INTO MEDICARE PRESCRIPTION DRUG ACCOUNT.—Section 1860D–16(c) of such Act (42 U.S.C. 1395w–116(c)) is amended by adding at the end the following new paragraph:

''(6) REBATE FOR REBATE ELIGIBLE MEDICARE DRUG PLAN ENROLLEES.—Amounts paid under a rebate agreement under section 1860D–2(f) shall be deposited into the Account and shall be used to pay

for all or part of the gradual elimination of the coverage gap under section 1860D–2(b)(7).''.

SEC. 1182. DISCOUNTS FOR CERTAIN PART D DRUGS IN ORIGINAL COVERAGE GAP.

Section 1860D–2 of the Social Security Act (42 U.S.C. 1395w–102), as amended by section 1181, is amended—

(1) in subsection (b)(4)(C)(ii), by inserting ''subject to subsection (g)(2)(C),'' after ''(ii)'';

(2) in subsection (e)(1), in the matter before subparagraph (A), by striking ''subsection (f)'' and inserting ''subsections (f) and (g)'' after ''this subsection''; and

(3) by adding at the end the following new subsection:

''(g) REQUIREMENT FOR MANUFACTURER DISCOUNT AGREEMENT FOR CERTAIN QUALIFYING DRUGS.—

''(1) IN GENERAL.—In this part, the term 'covered part D drug' does not include any drug or biological product that is manufactured by a manufacturer that has not entered into and have in effect for all qualifying drugs (as defined in paragraph (5)(A)) a discount agreement described in paragraph (2).

''(2) DISCOUNT AGREEMENT.—

''(A) PERIODIC DISCOUNTS.—A discount agreement under this paragraph shall require the manufacturer involved to provide, to each PDP sponsor with respect to a prescription drug plan or each MA organization with respect to each MA–PD plan, a discount in an amount specified in paragraph (3) for qualifying drugs (as defined in paragraph (5)(A)) of the manufacturer dispensed to a qualifying enrollee after January 1, 2010, insofar as the individual is in the original gap in coverage (as defined in paragraph (5)(E)).

''(B) DISCOUNT AGREEMENT.—Insofar as not inconsistent with this subsection, the Secretary shall establish terms and conditions of such agreement, including terms and conditions relating to compliance, similar to the terms and conditions for rebate agreements under paragraphs (2), (3), and (4) of section 1927(b), except that—

''(i) discounts shall be applied under this subsection to prescription drug plans and MA–PD plans instead of State plans under title XIX;

''(ii) PDP sponsors and MA organizations shall be responsible, instead of States, for provision of necessary utilization information to drug manufacturers; and

''(iii) sponsors and MA organizations shall be responsible for reporting information on drug-component negotiated price.

''(C) COUNTING DISCOUNT TOWARD TRUE OUT-OF-POCKET COSTS.—Under the discount agreement, in applying subsection (b)(4), with regard to subparagraph (C)(i) of such subsection, if a qualified enrollee purchases the qualified drug insofar as the enrollee is in an actual gap of coverage (as defined in paragraph (5)(D)), the amount of the discount under the agreement shall be treated and counted as costs incurred by the plan enrollee.

''(3) DISCOUNT AMOUNT.—The amount of the discount specified in this paragraph for a discount period for a plan is equal to 50 percent of the amount of the drug-component negotiated price (as defined in paragraph (5)(C)) for qualifying drugs for the period involved.

''(4) ADDITIONAL TERMS.—In the case of a discount provided under this subsection with respect to a prescription drug plan offered by a PDP sponsor or an MA–PD plan offered by an MA organization, if a qualified enrollee purchases the qualified drug—

''(A) insofar as the enrollee is in an actual gap of coverage (as defined in paragraph (5)(D)), the sponsor or plan shall provide the discount to the enrollee at the time the enrollee pays for the drug; and

''(B) insofar as the enrollee is in the portion of the original gap in coverage (as defined in paragraph (5)(E)) that is not in the actual gap in coverage, the discount shall not be applied against the negotiated price (as defined in subsection (d)(1)(B)) for the purpose of calculating the beneficiary payment.

''(5) DEFINITIONS.—In this subsection:

''(A) QUALIFYING DRUG.—The term 'qualifying drug' means, with respect to a prescription drug plan or MA–PD plan, a drug or biological product that—

''(i)(I) is a drug produced or distributed under an original new drug application approved by the Food and Drug Ad-

ministration, including a drug product marketed by any cross-licensed producers or distributors operating under the new drug application;

''(II) is a drug that was originally marketed under an original new drug application approved by the Food and Drug Administration; or

''(III) is a biological product as approved under Section 351(a) of the Public Health Services Act;

''(ii) is covered under the formulary of the plan or is treated as covered under the formulary of the plan as a result of a coverage determination or appeal under subsection (g) or (h) of section 1860D–4; and

''(iii) is dispensed to an individual who is in the original gap in coverage.

''(B) QUALIFYING ENROLLEE.—The term 'qualifying enrollee' means an individual enrolled in a prescription drug plan or MA–PD plan other than such an individual who is a subsidy-eligible individual (as defined in section 1860D–14(a)(3)).

''(C) DRUG-COMPONENT NEGOTIATED PRICE.—The term 'drug-component negotiated price' means, with respect to a qualifying drug, the negotiated price (as defined in section 423.100 of title 42, Code of Federal Regulations, as in effect on the date of enactment of this subsection), as determined without regard to any dispensing fee, of the drug under the prescription drug plan or MA–PD plan involved.

''(D) ACTUAL GAP IN COVERAGE.—The term 'actual gap in coverage' means the gap in prescription drug coverage that occurs between the initial coverage limit (as modified under paragraph (7) and subparagraph (B) of paragraph (8) of subsection (b)) and the annual out-of-pocket threshold (as modified under subparagraph (C) of such subsection).

''(E) ORIGINAL GAP IN COVERAGE.—The term 'original in gap coverage' means the gap in prescription drug coverage that would occur between the initial coverage limit (described in subsection (b)(3)) and the out-of-pocket threshold (as defined in subsection (b)(4)(B)) if subsections (b)(7) and (b)(8) did not apply.

''(6) SPECIAL RULE FOR 2010.—For the period beginning January 1, 2010, and ending December 31, 2010, the Secretary may—

''(A) enter into agreements with manufacturers to directly receive the discount amount described in paragraph (3);

''(B) collect the necessary information from prescription drug plans and MA-PD plans to calculate the discount amount described in such paragraph; and

''(C) provide the discount described in such paragraph to beneficiaries as close as practicable after the point of sale.

''(7) WAIVER.—Chapter 35 of title 44, United States Code, shall not apply to the requirements under this subsection for the period beginning on January 1, 2010, and ending on December 31, 2010.''.

SEC. 1183. REPEAL OF PROVISION RELATING TO SUBMISSION OF CLAIMS BY PHARMACIES LOCATED IN OR CONTRACTING WITH LONG-TERM CARE FACILITIES.

(a) PART D SUBMISSION.—Section 1860D–12(b) of the Social Security Act (42 U.S.C. 1395w–112(b)), as amended by section 172(a)(1) of Public Law 110–275, is

amended by striking paragraph (5) and redesignating paragraph (6) and paragraph (7), as added by section 1181(c)(2)(A), as paragraph (5) and paragraph (6), respectively.

(b) SUBMISSION TO MA–PD PLANS.—Section 1857(f)(3) of the Social Security Act (42 U.S.C. 1395w-27(f)(3)), as added by section 171(b) of Public Law 110–275 and amended by section 172(a)(2) of such Public Law and section 1181 of this Act, is amended by striking subparagraph (B) and redesignating subparagraphs (C) and (D) as subparagraphs (B) and (C) respectively.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply for contract years beginning with 2010.

SEC. 1184. INCLUDING COSTS INCURRED BY AIDS DRUG ASSISTANCE PROGRAMS AND INDIAN HEALTH SERVICE IN PROVIDING PRESCRIPTION DRUGS TOWARD THE ANNUAL OUT-OF-POCKET THRESHOLD UNDER PART D.

(a) IN GENERAL.—Section 1860D–2(b)(4)(C) of the Social Security Act (42 U.S.C. 1395w–102(b)(4)(C)) is amended—

(1) in clause (i), by striking ''and'' at the end;

(2) in clause (ii)—

(A) by striking ''such costs shall be treated as incurred only if'' and inserting ''and subject to clause (iii), such costs shall be treated as incurred only if'';

(B) by striking '', under section 1860D–14, or under a State Pharmaceutical Assistance Program''; and

(C) by striking the period at the end and inserting ''; and''; and

(3) by inserting after clause (ii) the following new clause:

''(iii) such costs shall be treated as incurred and shall not be considered to be reimbursed under clause (ii) if such costs are borne or paid—

''(I) under section 1860D–14;

''(II) under a State Pharmaceutical Assistance Program;

''(III) by the Indian Health Service, an Indian tribe or tribal organization, or an urban Indian organization (as defined in section 4 of the Indian Health Care Improvement Act); or

''(IV) under an AIDS Drug Assistance Program under part B of

title XXVI of the Public Health Service Act.''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to costs incurred on or after January 1, 2011.

SEC. 1185. NO MID-YEAR FORMULARY CHANGES PERMITTED.

(a) IN GENERAL.—Section 1860D–4(b)(3)(E) of the Social Security Act (42 U.S.C. 1395w–104(b)(3)(E)) is amended—

(1) in the heading, by inserting ''; CERTAIN FORMULARY CHANGES ONLY BEFORE INITIATING MARKETING FOR A PLAN YEAR'' after ''STATUS OF DRUG'';

(2) by striking ''Any removal'' and inserting ''(i) NOTICE.—Any removal'' with the same indentation as the clause added by paragraph (2);

(3) by adding at the end the following new clause:

''(ii) CERTAIN CHANGES IN FORMULARY ONLY BEFORE INITIATING MARKETING FOR A PLAN YEAR.—Any removal of a covered part D drug from a formulary used by a PDP sponsor of a prescription drug plan (or MA organization of a MA–

PD plan) or any other material change to the formulary so as to reduce the coverage (or increase the cost-sharing) of the drug under the plan for a plan year shall take effect by a date specified by the Secretary but no later than the start of plan marketing activities for the plan year. In addition to any exceptions to the previous sentence specified by the Secretary, the previous sentence shall not apply in the case that a drug is removed from the formulary of a plan because of a recall or withdrawal of the drug issued by the Food and Drug Administration, because the drug is replaced with a generic drug that is a therapeutic equivalent, or because of utilization management applied to—

''(I) a drug whose labeling includes a boxed warning required by the Food and Drug Administration under section 201.57(c)(1) of title 21, Code of Federal Regulations (or a successor regulation); or

''(II) a drug required under subsection (c)(2) of section 505–1 of the

Federal Food, Drug, and Cosmetic Act to have a Risk Evaluation and Management Strategy that includes elements under subsection (f) of such section.''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to contract years beginning on or after January 1, 2011.

SEC. 1186. NEGOTIATION OF LOWER COVERED PART D DRUG PRICES ON BEHALF OF MEDICARE BENEFICIARIES.

(a) NEGOTIATION BY SECRETARY.—Section 1860D–11 of the Social Security Act (42 U.S.C. 1395w–111) is amended by striking subsection (i) (relating to noninterference) and inserting the following:

''(i) NEGOTIATION OF LOWER DRUG PRICES.—

''(1) IN GENERAL.—Notwithstanding any other provision of law, the Secretary shall negotiate with pharmaceutical manufacturers the prices (including discounts, rebates, and other price concessions) that may be charged to PDP sponsors and MA organizations for covered part D drugs for part D eligible individuals who are enrolled under a prescription drug plan or under an MA-PD plan.

''(2) NO CHANGE IN RULES FOR FORMULARIES.—

''(A) IN GENERAL.—Nothing in paragraph (1) shall be construed to authorize the Secretary to establish or require a particular formulary.

''(B) CONSTRUCTION.—Subparagraph (A) shall not be construed as affecting the Secretary's authority to ensure appropriate and adequate access to covered part D drugs under prescription drug plans and under MA-PD plans, including compliance of such plans with formulary requirements under section 1860D–4(b)(3).

''(3) CONSTRUCTION.—Nothing in this subsection shall be construed as preventing the sponsor of a prescription drug plan, or an organization offering an MA-PD plan, from obtaining a discount or reduction of the price for a covered part D drug below the price negotiated under paragraph (1).

''(4) ANNUAL REPORTS TO CONGRESS.—Not later than June 1, 2011, and annually thereafter, the Secretary shall submit to the Committees on Ways and Means, Energy and Commerce, and Oversight and Government Reform of the House of Rep-

resentatives and the Committee on Finance of the Senate a report on negotiations conducted by the Secretary to achieve lower prices for Medicare beneficiaries, and the prices and price discounts achieved by the Secretary as a result of such negotiations.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect on the date of the enactment of this Act and shall first apply to negotiations and prices for plan years beginning on January 1, 2011.

SEC. 1187. ACCURATE DISPENSING IN LONG-TERM CARE FACILITIES.

Section 1860D–4(c) of the Social Security Act (42 U.S.C. 1395w–104(c)) is amended by adding at the end the following new paragraph:

''(3) REDUCTION OF WASTEFUL DISPENSING.—

''(A) IN GENERAL.—For plan years beginning on or after January 1, 2012, a PDP sponsor offering a prescription drug plan and MA organization offering a MA–PD plan under part C shall have in place the utilization management techniques established under subparagraph (B).

''(B) REQUIREMENTS.—The Secretary shall establish utilization management techniques, such as daily, weekly, or automated

dose dispensing, to apply to PDP sponsors and MA organizations to reduce the quantities of covered part D drugs dispensed to enrollees who are residing in long-term care facilities in order to reduce waste associated with unused medications.

''(C) CONSULTATION.—In establishing the requirements under subparagraph (A), the Secretary shall consult with the Administrator of the Environmental Protection Agency, Administrator of the Food and Drug Administration, Administrator of the Drug Enforcement Administration, State Boards of Pharmacy, pharmacy and physician organizations, and other appropriate stakeholders to study and determine additional methods for prescription drug plans to reduce waste associated with unused prescription drugs.''.

SEC. 1188. FREE GENERIC FILL.

(a) IN GENERAL.—Section 1128A(i)(6) of the Social Security Act (42 U.S.C. 1320a–7a(i)(6)) is amended—

(1) in subparagraph (C), by striking ''of 1996'' and all that follows and inserting ''of 1996;'';

(2) in the first subparagraph (D), by striking ''promulgated'' and all that follows and inserting ''promulgated;'';

(3) by redesignating the second subparagraph (D) as a subparagraph (E) and by striking the period at the end of such subparagraph and inserting ''; and''; and

(4) by adding at the end the following new subparagraph:

''(F) with regard to a prescription drug plan offered by a PDP sponsor or an MA–PD plan offered by an MA organization, a reduction in or waiver of the copayment amount under the plan given to an individual to induce the individual to switch to a generic, bioequivalent drug, or biosimilar.''.

(b) EFFECTIVE DATE.—The amendments made by this subsection shall take effect on the date of the enactment of this Act and shall first apply with respect to remuneration offered, paid, solicited, or received on or after January 1, 2011.

SEC. 1189. STATE CERTIFICATION PRIOR TO WAIVER OF LICENSURE REQUIREMENTS UNDER MEDICARE PRESCRIPTION DRUG PROGRAM.

(a) IN GENERAL.—Section 1860D–12(c) of the Social Security Act (42 U.S.C. 1395w–112(c)) is amended—

(1) in paragraph (1)(A), by striking ''In the case'' and inserting ''Subject to paragraph (5), in the case''; and

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

''(5) STATE CERTIFICATION REQUIRED.—

''(A) IN GENERAL.—Except as provided in section 1860D–21(f)(4), the Secretary may only grant a waiver under paragraph (1)(A) if the Secretary has received a certification from the State insurance commissioner that the prescription drug plan has a substantially complete application pending in the State.

''(B) REVOCATION OF WAIVER UPON FINDING OF FRAUD AND ABUSE.—The Secretary shall revoke a waiver granted under paragraph (1)(A) if the State insurance commissioner submits a certification to the Secretary that the recipient of such a waiver—

''(i) has committed fraud or abuse with respect to such waiver;

''(ii) has failed to make a good faith effort to satisfy State licensing requirements; or

''(iii) was determined ineligible for licensure by the State.''.

(b) EXCEPTION FOR PACE PROGRAMS.—Section 1860D–21(f) of such Act (42 U.S.C. 1395w–131(f)) is amended—

(1) in paragraph (1), by striking ''paragraphs (2) and (3)'' and inserting ''the succeeding paragraphs''; and

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

''(4) INAPPLICABILITY OF CERTAIN LICENSURE WAIVER REQUIREMENTS.—The provisions of paragraph (1) of section 1860D–12(c) (relating to waiver of licensure under certain circumstances) shall apply without regard to paragraph (5) of such section in the case of a PACE program that elects to provide qualified prescription drug coverage to a part D eligible individual who is enrolled under such program.''.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to plan years beginning on or after January 1, 2010.

Subtitle F—Medicare Rural Access Protections

SEC. 1191. TELEHEALTH EXPANSION AND ENHANCEMENTS.

(a) ADDITIONAL TELEHEALTH SITE.—

(1) IN GENERAL.—Paragraph (4)(C)(ii) of section 1834(m) of the Social Security Act (42 U.S.C. 1395m(m)) is amended by adding at the end the following new subclause:

''(IX) A renal dialysis facility.''

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to services furnished on or after January 1, 2011.

(b) TELEHEALTH ADVISORY COMMITTEE.—

(1) ESTABLISHMENT.—Section 1868 of the Social Security Act (42 U.S.C. 1395ee) is amended—

(A) in the heading, by adding at the end the following: ''TELEHEALTH ADVISORY COMMITTEE''; and

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

''(c) TELEHEALTH ADVISORY COMMITTEE.—

''(1) IN GENERAL.—The Secretary shall appoint a Telehealth Advisory Committee (in this subsection referred to as the 'Advisory Committee') to make recommendations to the Secretary on policies of the

Centers for Medicare & Medicaid Services regarding telehealth services as established under section 1834(m), including the appropriate addition or deletion of services (and HCPCS codes) to those specified in paragraphs (4)(F)(i) and (4)(F)(ii) of such section and for authorized payment under paragraph (1) of such section.

''(2) MEMBERSHIP; TERMS.—

''(A) MEMBERSHIP.—

''(i) IN GENERAL.—The Advisory Committee shall be composed of 9 members, to be appointed by the Secretary, of whom—

''(I) 5 shall be practicing physicians;

''(II) 2 shall be practicing non-physician health care practitioners; and

''(III) 2 shall be administrators of telehealth programs.

''(ii) REQUIREMENTS FOR APPOINTING MEMBERS.—In appointing members of the Advisory Committee, the Secretary shall—

''(I) ensure that each member has prior experience with the practice of telemedicine or telehealth;

''(II) give preference to individuals who are currently providing telemedicine or telehealth services or who are involved in telemedicine or telehealth programs;

''(III) ensure that the membership of the Advisory Committee represents a balance of specialties and geographic regions; and

''(IV) take into account the recommendations of stakeholders.

''(B) TERMS.—The members of the Advisory Committee shall serve for such term as the Secretary may specify.

''(C) CONFLICTS OF INTEREST.—An advisory committee member may not participate with respect to a particular matter considered in an advisory committee meeting if such member (or an immediate family member of such member) has a financial interest that could be affected by the advice given to the Secretary with respect to such matter.

''(3) MEETINGS.—The Advisory Committee shall meet twice each calendar year and at such other times as the Secretary may provide.

''(4) PERMANENT COMMITTEE.—Section 14 of the Federal Advisory Committee Act (5 U.S.C. App.) shall not apply to the Advisory Committee.''

(2) FOLLOWING RECOMMENDATIONS.—Section 1834(m)(4)(F) of such Act (42 U.S.C. 1395m(m)(4)(F)) is amended by adding at the end the following new clause:

''(iii) RECOMMENDATIONS OF THE TELEHEALTH ADVISORY COMMITTEE.—In making determinations under clauses (i) and (ii), the Secretary shall take into account the recommendations of the Telehealth Advisory Committee (established under section 1868(c)) when adding or deleting services (and HCPCS codes) and in establishing policies of the Centers for Medicare & Medicaid Services regarding the delivery of telehealth services. If the Secretary does not implement such a recommendation, the Secretary shall publish in the Federal Register a statement re-

garding the reason such recommendation was not implemented.''

(3) WAIVER OF ADMINISTRATIVE LIMITATION.—The Secretary of Health and Human Services shall establish the Telehealth Advisory Committee under the amendment made by paragraph (1) notwithstanding any limitation that may apply to the number of advisory committees that may be established (within the Department of Health and Human Services or otherwise).

(c) HOSPITAL CREDENTIALING OF TELEMEDICINE PHYSICIANS AND PRACTITIONERS.—

(1) IN GENERAL.—Not later than 60 days after the date of the enactment of this Act, the Secretary of Health and Human Services shall issue guidance for hospitals (as defined in paragraph (4)) to simplify requirements regarding compiling practitioner credentials for the purpose of rendering a medical staff privileging decision (under bylaws of the type described in section 1861(e)(3) of the Social Security Act) for physicians and practitioners (as defined in paragraph (4)) delivering telehealth services that are furnished via a telecommunications system.

(2) FLEXIBILITY IN ACCEPTING CREDENTIALING BY ANOTHER MEDICARE PARTICIPATING HOSPITAL.—

(A) IN GENERAL.—Such guidance shall permit a hospital to accept credentialing packages compiled by another hospital participating under Medicare with regard to physicians and practitioners who seek medical staff privileges in the hospital to provide telehealth services via a telecommunications system from a site other than the hospital where the patient is located.

(B) CONSTRUCTION.—Nothing in this subsection shall be construed to require a hospital to accept the credentialing package compiled by another facility.

(C) NO OVERSIGHT REQUIRED.—If a hospital does accept the credentialing materials prepared by another hospital, the hospital shall not be required to exercise oversight over the other hospital's process for compiling and verifying credentials.

(D) PRIVILEGING.—This paragraph shall only apply to credentialing and does not relieve a hospital from any applicable privileging requirements.

(3) CONSTRUCTION.—This subsection shall not be construed as limiting the ability of the Secretary to issue additional guidance regarding the requirements for the compilation of credentials for physicians and practitioners not described in paragraph (1).

(4) DEFINITIONS.—In this subsection:

(A) The term ''hospital'' has the meaning given such term in subsection (e) of section 1861 of the Social Security Act (42 U.S.C. 1395x) and includes a critical access hospital (as defined in subsection (mm)(1) of such section).

(B) The term ''physician'' has the meaning given such term in subsection (r) of such section.

(C) The term ''practitioner'' means a practitioner described in section 1842(b)(18)(C) of the Social Security Act (42 U.S.C. 1395u(b)(18)(C)).

SEC. 1192. EXTENSION OF OUTPATIENT HOLD HARMLESS PROVISION.

Section 1833(t)(7)(D)(i) of the Social Security Act (42 U.S.C. 1395l(t)(7)(D)(i)) is amended—

(1) in subclause (II)—

(A) in the first sentence, by striking `"2010" and inserting "2012"; and

(B) in the second sentence, by striking "or 2009" and inserting ", 2009, 2010, or 2011"; and

(2) in subclause (III), by striking "January 1, 2010" and inserting "January 1, 2012".

SEC. 1193. EXTENSION OF SECTION 508 HOSPITAL RECLASSIFICATIONS.

(a) IN GENERAL.—Subsection (a) of section 106 of division B of the Tax Relief and Health Care Act of 2006 (42 U.S.C. 1395 note), as amended by section 117 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (Public Law 110–173) and section 124 of the Medicare Improvements for Patients and Providers Act of 2008 (Public Law 110–275), is amended by striking "September 30, 2009" and inserting "September 30, 2011".

(b) USE OF PARTICULAR WAGE INDEX FOR FISCAL YEAR 2010.—For purposes of implementation of the amendment made by subsection (a) for fiscal year 2010, the Secretary shall use the hospital wage index that was promulgated by the Secretary in the Federal Register on August 27, 2009 (74 Fed. Reg. 43754), and any subsequent corrections.

SEC. 1194. EXTENSION OF GEOGRAPHIC FLOOR FOR WORK.

Section 1848(e)(1)(E) of the Social Security Act (42 U.S.C. 1395w–4(e)(1)(E)) is amended by striking ''before January 1, 2010'' and inserting ''before January 1, 2012''.

SEC. 1195. EXTENSION OF PAYMENT FOR TECHNICAL COMPONENT OF CERTAIN PHYSICIAN PATHOLOGY SERVICES.

Section 542(c) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (as enacted into law by section 1(a)(6) of Public Law 106–554), as amended by section 732 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (42 U.S.C. 1395w–4 note), section 104 of division B of the Tax Relief and Health Care Act of 2006 (42 U.S.C. 1395w–4 note), section 104 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (Public Law 110–173), and section 136 of the Medicare Improvements for Patients and Providers Act of 1008 (Public Law 110–275), is amended by striking ''and 2009'' and inserting ''2009, 2010, and 2011''.

SEC. 1196. EXTENSION OF AMBULANCE ADD-ONS.

(a) IN GENERAL.—Section 1834(l)(13) of the Social Security Act (42 U.S.C. 1395m(l)(13)) is amended—

(1) in subparagraph (A)—

(A) in the matter preceding clause (i), by striking ''before January 1, 2010'' and inserting ''before January 1, 2012''; and

(B) in each of clauses (i) and (ii), by striking ''before January 1, 2010'' and inserting ''before January 1, 2012''.

(b) AIR AMBULANCE IMPROVEMENTS.—Section 146(b)(1) of the Medicare Improvements for Patients and Providers Act of 2008 (Public Law 110–275) is amended by striking ''ending on December 31, 2009'' and inserting ''ending on December 31, 2011''.

TITLE II—MEDICARE BENEFICIARY IMPROVEMENTS

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

SEC. 1201. IMPROVING ASSETS TESTS FOR MEDICARE SAVINGS PROGRAM AND LOW-INCOME SUBSIDY PROGRAM.

(a) APPLICATION OF HIGHEST LEVEL PERMITTED UNDER LIS TO ALL SUBSIDY ELIGIBLE INDIVIDUALS.—

(1) IN GENERAL.—Section 1860D–14(a)(1) of the Social Security Act (42 U.S.C. 1395w–114(a)(1)) is amended in the matter before subpara-

graph (A), by inserting ''(or, beginning with 2012, paragraph (3)(E))'' after ''paragraph (3)(D)''.

(2) ANNUAL INCREASE IN LIS RESOURCE TEST.—Section 1860D–14(a)(3)(E)(i) of such Act (42 U.S.C. 1395w–114(a)(3)(E)(i)) is amended—

(A) by striking ''and'' at the end of subclause (I);

(B) in subclause (II), by inserting ''(before 2012)'' after ''subsequent year'';

(C) by striking the period at the end of subclause (II) and inserting a semicolon;

(D) by inserting after subclause (II) the following new subclauses:

''(III) for 2012, $17,000 (or $34,000 in the case of the combined value of the individual's assets or resources and the assets or resources of the individual's spouse); and

''(IV) for a subsequent year, the dollar amounts specified in this subclause (or subclause (III)) for the previous year increased by the annual percentage increase in the consumer price index (all items; U.S. city aver-

age) as of September of such previous year.''; and

(E) in the last sentence, by inserting ''or (IV)'' after ''subclause (II)''.

(3) APPLICATION OF LIS TEST UNDER MEDICARE SAVINGS PROGRAM.—Section 1905(p)(1)(C) of such Act (42 U.S.C. 1396d(p)(1)(C)) is amended—

(A) by striking ''effective beginning with January 1, 2010'' and inserting ''effective for the period beginning with January 1, 2010, and ending with December 31, 2011''; and

(B) by inserting before the period at the end the following: ''or, effective beginning with January 1, 2012, whose resources (as so determined) do not exceed the maximum resource level applied for the year under subparagraph (E) of section 1860D–14(a)(3) (determined without regard to the life insurance policy exclusion provided under subparagraph (G) of such section) applicable to an individual or to the individual and the individual's spouse (as the case may be)''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to eligibility determinations for

income-related subsidies and medicare cost-sharing furnished for periods beginning on or after January 1, 2012.

SEC. 1202. ELIMINATION OF PART D COST-SHARING FOR CERTAIN NON-INSTITUTIONALIZED FULL-BENEFIT DUAL ELIGIBLE INDIVIDUALS.

(a) IN GENERAL.—Section 1860D–14(a)(1)(D)(i) of the Social Security Act (42 U.S.C. 1395w–114(a)(1)(D)(i)) is amended—

(1) by striking ''INSTITUTIONALIZED INDIVIDUALS.—In'' and inserting ''ELIMINATION OF COST-SHARING FOR CERTAIN FULL-BENEFIT DUAL ELIGIBLE INDIVIDUALS.—

''(I) INSTITUTIONALIZED INDIVIDUALS.—In''; and

(2) by adding at the end the following new subclause:

''(II) CERTAIN OTHER INDIVIDUALS.—In the case of an individual who is a full-benefit dual eligible individual and with respect to whom there has been a determination that but for the provision of home and community based care (whether under section 1915, 1932, or under a waiver under section 1115) the individual would re-

quire the level of care provided in a hospital or a nursing facility or intermediate care facility for the mentally retarded the cost of which could be reimbursed under the State plan under title XIX, the elimination of any beneficiary coinsurance described in section 1860D–2(b)(2) (for all amounts through the total amount of expenditures at which benefits are available under section 1860D–2(b)(4)).''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to drugs dispensed on or after January 1, 2011.

SEC. 1203. ELIMINATING BARRIERS TO ENROLLMENT.

(a) ADMINISTRATIVE VERIFICATION OF INCOME AND RESOURCES UNDER THE LOW-INCOME SUBSIDY PROGRAM.—

(1) IN GENERAL.—Clause (iii) of section 1860D–14(a)(3)(E) of the Social Security Act (42 U.S.C. 1395w–114(a)(3)(E)) is amended to read as follows:

''(iii) CERTIFICATION OF INCOME AND RESOURCES.—For purposes of applying this section—

''(I) an individual shall be permitted to apply on the basis of self-certification of income and resources; and

''(II) matters attested to in the application shall be subject to appropriate methods of verification without the need of the individual to provide additional documentation, except in extraordinary situations as determined by the Commissioner.''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply beginning January 1, 2010.

(b) DISCLOSURES TO FACILITATE IDENTIFICATION OF INDIVIDUALS LIKELY TO BE INELIGIBLE FOR THE LOW-INCOME ASSISTANCE UNDER THE MEDICARE PRESCRIPTION DRUG PROGRAM TO ASSIST SOCIAL SECURITY ADMINISTRATION'S OUTREACH TO ELIGIBLE INDIVIDUALS.—For provision authorizing disclosure of return information to facilitate identification of individuals likely to be ineligible for low-income subsidies under Medicare prescription drug program, see section 1801.

SEC. 1204. ENHANCED OVERSIGHT RELATING TO REIMBURSEMENTS FOR RETROACTIVE LOW INCOME SUBSIDY ENROLLMENT.

(a) IN GENERAL.—In the case of a retroactive LIS enrollment beneficiary who is enrolled under a prescription drug plan under part D of title XVIII of the Social Security Act (or an MA–PD plan under part C of such title), the beneficiary (or any eligible third party) is entitled to reimbursement by the plan for covered drug costs incurred by the beneficiary during the retroactive coverage period of the beneficiary in accordance with subsection (b) and in the case of such a beneficiary described in subsection (c)(4)(A)(i), such reimbursement shall be made automatically by the plan upon receipt of appropriate notice the beneficiary is eligible for assistance described in such subsection (c)(4)(A)(i) without further information required to be filed with the plan by the beneficiary.

(b) ADMINISTRATIVE REQUIREMENTS RELATING TO REIMBURSEMENTS.—

(1) LINE-ITEM DESCRIPTION.—Each reimbursement made by a prescription drug plan or MA–PD plan under subsection (a) shall include a line-item description of the items for which the reimbursement is made.

(2) TIMING OF REIMBURSEMENTS.—A prescription drug plan or MA–PD plan must make a reim-

bursement under subsection (a) to a retroactive LIS enrollment beneficiary, with respect to a claim, not later than 45 days after—

(A) in the case of a beneficiary described in subsection (c)(4)(A)(i), the date on which the plan receives notice from the Secretary that the beneficiary is eligible for assistance described in such subsection; or

(B) in the case of a beneficiary described in subsection (c)(4)(A)(ii), the date on which the beneficiary files the claim with the plan.

(3) REPORTING REQUIREMENT.—For each month beginning with January 2011, each prescription drug plan and each MA–PD plan shall report to the Secretary the following:

(A) The number of claims the plan has readjudicated during the month due to a beneficiary becoming retroactively eligible for subsidies available under section 1860D–14 of the Social Security Act.

(B) The total value of the readjudicated claim amount for the month.

(C) The Medicare Health Insurance Claims Number of beneficiaries for whom claims were readjudicated.

(D) For the claims described in subparagraphs (A) and (B), an attestation to the Administrator of the Centers for Medicare & Medicaid Services of the total amount of reimbursement the plan has provided to beneficiaries for premiums and cost-sharing that the beneficiary overpaid for which the plan received payment from the Centers for Medicare & Medicaid Services.

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

(1) COVERED DRUG COSTS.—The term ''covered drug costs'' means, with respect to a retroactive LIS enrollment beneficiary enrolled under a prescription drug plan under part D of title XVIII of the Social Security Act (or an MA–PD plan under part C of such title), the amount by which—

(A) the costs incurred by such beneficiary during the retroactive coverage period of the beneficiary for covered part D drugs, premiums, and cost-sharing under such title; exceeds

(B) such costs that would have been incurred by such beneficiary during such period if the beneficiary had been both enrolled in the plan and recognized by such plan as qualified during such period for the low income subsidy

under section 1860D–14 of the Social Security Act to which the individual is entitled.

(2) ELIGIBLE THIRD PARTY.—The term ''eligible third party'' means, with respect to a retroactive LIS enrollment beneficiary, an organization or other third party that is owed payment on behalf of such beneficiary for covered drug costs incurred by such beneficiary during the retroactive coverage period of such beneficiary.

(3) RETROACTIVE COVERAGE PERIOD.—The term ''retroactive coverage period'' means—

(A) with respect to a retroactive LIS enrollment beneficiary described in paragraph (4)(A)(i), the period—

(i) beginning on the effective date of the assistance described in such paragraph for which the individual is eligible; and

(ii) ending on the date the plan effectuates the status of such individual as so eligible; and

(B) with respect to a retroactive LIS enrollment beneficiary described in paragraph (4)(A)(ii), the period—

(i) beginning on the date the individual is both entitled to benefits under

part A, or enrolled under part B, of title XVIII of the Social Security Act and eligible for medical assistance under a State plan under title XIX of such Act; and

(ii) ending on the date the plan effectuates the status of such individual as a full-benefit dual eligible individual (as defined in section 1935(c)(6) of such Act).

(4) RETROACTIVE LIS ENROLLMENT BENEFICIARY.—

(A) IN GENERAL.—The term ''retroactive LIS enrollment beneficiary'' means an individual who—

(i) is enrolled in a prescription drug plan under part D of title XVIII of the Social Security Act (or an MA–PD plan under part C of such title) and subsequently becomes eligible as a full-benefit dual eligible individual (as defined in section 1935(c)(6) of such Act), an individual receiving a low-income subsidy under section 1860D–14 of such Act, an individual receiving assistance under the Medicare Savings Program implemented under clauses (i), (iii), and (iv) of section

1902(a)(10)(E) of such Act, or an individual receiving assistance under the supplemental security income program under section 1611 of such Act; or

(ii) subject to subparagraph (B)(i), is a full-benefit dual eligible individual (as defined in section 1935(c)(6) of such Act) who is automatically enrolled in such a plan under section 1860D–1(b)(1)(C) of such Act.

(B) EXCEPTION FOR BENEFICIARIES ENROLLED IN RFP PLAN.—

(i) IN GENERAL.—In no case shall an individual described in subparagraph (A)(ii) include an individual who is enrolled, pursuant to a RFP contract described in clause (ii), in a prescription drug plan offered by the sponsor of such plan awarded such contract.

(ii) RFP CONTRACT DESCRIBED.—The RFP contract described in this section is a contract entered into between the Secretary and a sponsor of a prescription drug plan pursuant to the Centers for Medicare & Medicaid Services' request for proposals

issued on February 17, 2009, relating to Medicare part D retroactive coverage for certain low income beneficiaries, or a similar subsequent request for proposals.

SEC. 1205. INTELLIGENT ASSIGNMENT IN ENROLLMENT.

(a) IN GENERAL.—Section 1860D–1(b)(1)(C) of the Social Security Act (42 U.S.C. 1395w–101(b)(1)(C)) is amended by adding after ''PDP region'' the following: ''or through use of an intelligent assignment process that is designed to maximize the access of such individual to necessary prescription drugs while minimizing costs to such individual and to the program under this part to the greatest extent possible. In the case the Secretary enrolls such individuals through use of an intelligent assignment process, such process shall take into account the extent to which prescription drugs necessary for the individual are covered in the case of a PDP sponsor of a prescription drug plan that uses a formulary, the use of prior authorization or other restrictions on access to coverage of such prescription drugs by such a sponsor, and the overall quality of a prescription drug plan as measured by quality ratings established by the Secretary''

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect for contract years beginning with 2012.

SEC. 1206. SPECIAL ENROLLMENT PERIOD AND AUTOMATIC ENROLLMENT PROCESS FOR CERTAIN SUBSIDY ELIGIBLE INDIVIDUALS.

(a) SPECIAL ENROLLMENT PERIOD.—Section 1860D–1(b)(3)(D) of the Social Security Act (42 U.S.C. 1395w–101(b)(3)(D)) is amended to read as follows:

''(D) SUBSIDY ELIGIBLE INDIVIDUALS.—In the case of an individual (as determined by the Secretary) who is determined under subparagraph (B) of section 1860D–14(a)(3) to be a subsidy eligible individual.''.

(b) AUTOMATIC ENROLLMENT.—Section 1860D–1(b)(1) of the Social Security Act (42 U.S.C. 1395w–101(b)(1)) is amended by adding at the end the following new subparagraph:

''(D) SPECIAL RULE FOR SUBSIDY ELIGIBLE INDIVIDUALS.—The process established under subparagraph (A) shall include, in the case of an individual described in section 1860D–1(b)(3)(D) who fails to enroll in a prescription drug plan or an MA–PD plan during the special enrollment established under such section applicable to such individual, the application of the assignment process described in subparagraph (C) to such individual in the same manner as such assignment process ap-

plies to a part D eligible individual described in such subparagraph (C). Nothing in the previous sentence shall prevent an individual described in such sentence from declining enrollment in a plan determined appropriate by the Secretary (or in the program under this part) or from changing such enrollment.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to subsidy determinations made for months beginning with January 2011.

SEC. 1207. APPLICATION OF MA PREMIUMS PRIOR TO REBATE AND QUALITY BONUS PAYMENTS IN CALCULATION OF LOW INCOME SUBSIDY BENCHMARK.

(a) IN GENERAL.—Section 1860D–14(b)(2)(B)(iii) of the Social Security Act (42 U.S.C. 1395w–114(b)(2)(B)(iii)) is amended by inserting before the period the following: ''before the application of the monthly rebate computed under section 1854(b)(1)(C)(i) for that plan and year involved and, in the case of a qualifying plan in a qualifying county, before the application of the increase under section 1853(o) for that plan and year involved''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to subsidy determinations made for months beginning with January 2011.

Subtitle B—Reducing Health Disparities

SEC. 1221. ENSURING EFFECTIVE COMMUNICATION IN MEDICARE.

(a) ENSURING EFFECTIVE COMMUNICATION BY THE CENTERS FOR MEDICARE & MEDICAID SERVICES.—

(1) STUDY ON MEDICARE PAYMENTS FOR LANGUAGE SERVICES.—The Secretary of Health and Human Services shall conduct a study that examines the extent to which Medicare service providers utilize, offer, or make available language services for beneficiaries who are limited English proficient and ways that Medicare should develop payment systems for language services.

(2) ANALYSES.—The study shall include an analysis of each of the following:

(A) How to develop and structure appropriate payment systems for language services for all Medicare service providers.

(B) The feasibility of adopting a payment methodology for on-site interpreters, including interpreters who work as independent contrac-

tors and interpreters who work for agencies that provide on-site interpretation, pursuant to which such interpreters could directly bill Medicare for services provided in support of physician office services for an LEP Medicare patient.

(C) The feasibility of Medicare contracting directly with agencies that provide off-site interpretation including telephonic and video interpretation pursuant to which such contractors could directly bill Medicare for the services provided in support of physician office services for an LEP Medicare patient.

(D) The feasibility of modifying the existing Medicare resource-based relative value scale (RBRVS) by using adjustments (such as multipliers or add-ons) when a patient is LEP.

(E) How each of options described in a previous paragraph would be funded and how such funding would affect physician payments, a physician's practice, and beneficiary cost-sharing.

(F) The extent to which providers under parts A and B of title XVIII of the Social Security Act, MA organizations offering Medicare

Advantage plans under part C of such title and PDP sponsors of a prescription drug plan under part D of such title utilize, offer, or make available language services for beneficiaries with limited English proficiency.

(G) The nature and type of language services provided by States under title XIX of the Social Security Act and the extent to which such services could be utilized by beneficiaries and providers under title XVIII of such Act.

(H) The extent to which interpreters and translators providing services to Medicare beneficiaries under title XVIII of such Act are trained or accredited.

(3) VARIATION IN PAYMENT SYSTEM DESCRIBED.—The payment systems described in paragraph (2)(A) may allow variations based upon types of service providers, available delivery methods, and costs for providing language services including such factors as—

(A) the type of language services provided (such as provision of health care or health care related services directly in a non-English language by a bilingual provider or use of an interpreter);

(B) type of interpretation services provided (such as in-person, telephonic, video interpretation);

(C) the methods and costs of providing language services (including the costs of providing language services with internal staff or through contract with external independent contractors or agencies, or both);

(D) providing services for languages not frequently encountered in the United States; and

(E) providing services in rural areas.

(4) REPORT.—The Secretary shall submit a report on the study conducted under subsection (a) to appropriate committees of Congress not later than 12 months after the date of the enactment of this Act.

(5) EXEMPTION FROM PAPERWORK REDUCTION ACT.—Chapter 35 of title 44, United States Code (commonly known as the ''Paperwork Reduction Act''), shall not apply for purposes of carrying out this subsection.

(6) AUTHORIZATION OF APPROPRIATIONS.—The Secretary shall provide for the transfer, from the Federal Supplementary Medical Insurance Trust

Fund under section 1841 of the Social Security Act (42 U.S.C. 1395t) of $2,000,000 for purposes of carrying out this subsection.

(b) HEALTH PLANS.—Section 1857(g)(1) of the Social Security Act (42 U.S.C. 1395w–27(g)(1)) is amended—

(1) by striking ''or'' at the end of subparagraph (F);

(2) by adding ''or'' at the end of subparagraph (G); and

(3) by inserting after subparagraph (G) the following new subparagraph:

''(H) fails substantially to provide language services to limited English proficient beneficiaries enrolled in the plan that are required under law;''.

SEC. 1222. DEMONSTRATION TO PROMOTE ACCESS FOR MEDICARE BENEFICIARIES WITH LIMITED ENGLISH PROFICIENCY BY PROVIDING REIMBURSEMENT FOR CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES.

(a) IN GENERAL.—Not later than 6 months after the date of the completion of the study described in section 1221(a) of this Act, the Secretary, acting through the Centers for Medicare & Medicaid Services and the Center

for Medicare and Medicaid Innovation established under section 1115A of the Social Security Act (as added by section 1907) and consistent with the applicable provisions of such section, shall carry out a demonstration program under which the Secretary shall award not fewer than 24 3-year grants to eligible Medicare service providers (as described in subsection (b)(1)) to improve effective communication between such providers and Medicare beneficiaries who are living in communities where racial and ethnic minorities, including populations that face language barriers, are underserved with respect to such services. In designing and carrying out the demonstration the Secretary shall take into consideration the results of the study conducted under section 1221(a) of this Act and adjust, as appropriate, the distribution of grants so as to better target Medicare beneficiaries who are in the greatest need of language services. The Secretary shall not authorize a grant larger than $500,000 over three years for any grantee.

(b) ELIGIBILITY; PRIORITY.—

(1) ELIGIBILITY.—To be eligible to receive a grant under subsection (a) an entity shall—

(A) be—

(i) a provider of services under part A of title XVIII of the Social Security Act;

(ii) a service provider under part B of such title;

(iii) a part C organization offering a Medicare part C plan under part C of such title; or

(iv) a PDP sponsor of a prescription drug plan under part D of such title; and

(B) prepare and submit to the Secretary an application, at such time, in such manner, and accompanied by such additional information as the Secretary may require.

(2) PRIORITY.—

(A) DISTRIBUTION.—To the extent feasible, in awarding grants under this section, the Secretary shall award—

(i) at least 6 grants to providers of services described in paragraph (1)(A)(i);

(ii) at least 6 grants to service providers described in paragraph (1)(A)(ii);

(iii) at least 6 grants to organizations described in paragraph (1)(A)(iii); and

(iv) at least 6 grants to sponsors described in paragraph (1)(A)(iv).

(B) FOR COMMUNITY ORGANIZATIONS.—The Secretary shall give priority to applicants

that have developed partnerships with community organizations or with agencies with experience in language access.

(C) VARIATION IN GRANTEES.—The Secretary shall also ensure that the grantees under this section represent, among other factors—

(i) different types of language services provided and of service providers and organizations under parts A through D of title XVIII of the Social Security Act;

(ii) variations in languages needed and their frequency of use;

(iii) urban and rural settings;

(iv) at least two geographic regions, as defined by the Secretary; and

(v) at least two large metropolitan statistical areas with diverse populations.

(c) USE OF FUNDS.—

(1) IN GENERAL.—A grantee shall use grant funds received under this section to pay for the provision of competent language services to Medicare beneficiaries who are limited English proficient. Competent interpreter services may be provided through on-site interpretation, telephonic interpretation, or video interpretation or direct provision of

health care or health care related services by a bilingual health care provider. A grantee may use bilingual providers, staff, or contract interpreters. A grantee may use grant funds to pay for competent translation services. A grantee may use up to 10 percent of the grant funds to pay for administrative costs associated with the provision of competent language services and for reporting required under subsection (e).

(2) ORGANIZATIONS.—Grantees that are part C organizations or PDP sponsors must ensure that their network providers receive at least 50 percent of the grant funds to pay for the provision of competent language services to Medicare beneficiaries who are limited English proficient, including physicians and pharmacies.

(3) DETERMINATION OF PAYMENTS FOR LANGUAGE SERVICES.—Payments to grantees shall be calculated based on the estimated numbers of limited English proficient Medicare beneficiaries in a grantee's service area utilizing—

(A) data on the numbers of limited English proficient individuals who speak English less than ''very well'' from the most recently available data from the Bureau of the

Census or other State-based study the Secretary determines likely to yield accurate data regarding the number of such individuals served by the grantee; or

(B) the grantee's own data if the grantee routinely collects data on Medicare beneficiaries' primary language in a manner determined by the Secretary to yield accurate data and such data shows greater numbers of limited English proficient individuals than the data listed in subparagraph (A).

(4) LIMITATIONS.—

(A) REPORTING.—Payments shall only be provided under this section to grantees that report their costs of providing language services as required under subsection (e) and may be modified annually at the discretion of the Secretary. If a grantee fails to provide the reports under such section for the first year of a grant, the Secretary may terminate the grant and solicit applications from new grantees to participate in the subsequent two years of the demonstration program.

(B) TYPE OF SERVICES.—

(i) IN GENERAL.—Subject to clause (ii), payments shall be provided under this section only to grantees that utilize competent bilingual staff or competent interpreter or translation services which—

(I) if the grantee operates in a State that has statewide health care interpreter standards, meet the State standards currently in effect; or

(II) if the grantee operates in a State that does not have statewide health care interpreter standards, utilizes competent interpreters who follow the National Council on Interpreting in Health Care's Code of Ethics and Standards of Practice.

(ii) EXEMPTIONS.—The requirements of clause (i) shall not apply—

(I) in the case of a Medicare beneficiary who is limited English proficient (who has been informed in the beneficiary's primary language of the availability of free interpreter and translation services) and who requests the use of family, friends, or other

persons untrained in interpretation or translation and the grantee documents the request in the beneficiary's record; and

(II) in the case of a medical emergency where the delay directly associated with obtaining a competent interpreter or translation services would jeopardize the health of the patient.

Nothing in clause (ii)(II) shall be construed to exempt emergency rooms or similar entities that regularly provide health care services in medical emergencies from having in place systems to provide competent interpreter and translation services without undue delay.

(d) ASSURANCES.—Grantees under this section shall—

(1) ensure that appropriate clinical and support staff receive ongoing education and training in linguistically appropriate service delivery;

(2) ensure the linguistic competence of bilingual providers;

(3) offer and provide appropriate language services at no additional charge to each patient with limited English proficiency at all points of contact, in a timely manner during all hours of operation;

(4) notify Medicare beneficiaries of their right to receive language services in their primary language;

(5) post signage in the languages of the commonly encountered group or groups present in the service area of the organization; and

(6) ensure that—

(A) primary language data are collected for recipients of language services and are consistent with standards developed under section 1709(b)(3)(B)(iv) of the Public Health Service Act, as added by section 2402 of this Act, to the extent such standards are available upon the initiation of the demonstration; and

(B) consistent with the privacy protections provided under the regulations promulgated pursuant to section 264(c) of the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. 1320d–2 note), if the recipient of language services is a minor or is incapacitated,

the primary language of the parent or legal guardian is collected and utilized.

(e) REPORTING REQUIREMENTS.—Grantees under this section shall provide the Secretary with reports at the conclusion of the each year of a grant under this section. Each report shall include at least the following information:

(1) The number of Medicare beneficiaries to whom language services are provided.

(2) The languages of those Medicare beneficiaries.

(3) The types of language services provided (such as provision of services directly in non-English language by a bilingual health care provider or use of an interpreter).

(4) Type of interpretation (such as in-person, telephonic, or video interpretation).

(5) The methods of providing language services (such as staff or contract with external independent contractors or agencies).

(6) The length of time for each interpretation encounter.

(7) The costs of providing language services (which may be actual or estimated, as determined by the Secretary).

(8) An account of the training or accreditation of bilingual staff, interpreters, or translators providing services under this demonstration.

(f) NO COST SHARING.—Limited English proficient Medicare beneficiaries shall not have to pay cost-sharing or co-pays for language services provided through this demonstration program.

(g) EVALUATION AND REPORT.—The Secretary shall conduct an evaluation of the demonstration program under this section and shall submit to the appropriate committees of Congress a report not later than 1 year after the completion of the program. The report shall include the following:

(1) An analysis of the patient outcomes and costs of furnishing care to the limited English proficient Medicare beneficiaries participating in the project as compared to such outcomes and costs for limited English proficient Medicare beneficiaries not participating.

(2) The effect of delivering culturally and linguistically appropriate services on beneficiary access to care, utilization of services, efficiency and cost-effectiveness of health care delivery, patient satisfaction, and select health outcomes.

(3) The extent to which bilingual staff, interpreters, and translators providing services under such demonstration were trained or accredited and the nature of accreditation or training needed by type of provider, service, or other category as determined by the Secretary to ensure the provision of high-quality interpretation, translation, or other language services to Medicare beneficiaries if such services are expanded pursuant to subsection (c) of section 1907 of this Act.

(4) Recommendations, if any, regarding the extension of such project to the entire Medicare program.

(h) ACCREDITATION OR TRAINING FOR PROVIDERS OF INTERPRETATION, TRANSLATION OR LANGUAGE SERVICES IN MEDICARE.—

(1) IN GENERAL.—

(A) DESIGNATION OF STANDARDS.—If the Secretary, pursuant to section 1907(c) of this Act, expands the model initially developed through the demonstration program under this section, the Secretary shall use the results of the study under section 1221 and the demonstration under this section to designate standards for training or accreditation. The

Secretary may designate one or more training or accreditation organizations, as appropriate for the nature and type of interpretation and translation services provided to Medicare beneficiaries to ensure that payments are made only for approved services by trained or accredited language services providers.

(B) ALTERNATIVES TO TRAINING OR ACCREDITATION.—If the Secretary designates one or more training or accreditation organizations but determines that accreditation is not available in all languages for which payments may be initiated, the Secretary shall provide payments for and accept alternatives to training or accreditation for certain languages, including languages of lesser diffusion. The Secretary must ensure that the alternatives to training or accreditation provide, at a minimum—

(i) a determination that the interpreter is proficient and able to communicate information accurately in both English and in the language for which interpreting is needed;

(ii) an attestation from the interpreter to comply with and adhere to the role of an interpreter as defined by the National Code of Ethics and National Standards of Practice as published by the National Council on Interpreting in Health Care; and

(iii) an attestation to adhere to HIPAA privacy and security law, as defined in section 3009(a)(2) of the Public Health Service Act, to the same extent as the healthcare provider for whom interpreting is provided.

(C) MODIFIERS, ADD-ONS, AND OTHER FORMS OF PAYMENT.—If the Secretary decides that modifiers, add-ons, or other forms of payment may be made for the provision of services directly by bilingual providers, the Secretary shall designate standards to ensure the competency of such providers delivering such services in a non-English language.

(2) CONSULTATION WITH STAKEHOLDERS AND CONSIDERATIONS FOR ACCREDITATION OR TRAINING.—

(A) CONSULTATION.—In designating accreditation or training requirements under this subsection, the Secretary shall consult with patients, providers, organizations that advocate on behalf of limited English proficient individuals, and other individuals or entities determined appropriate by the Secretary.

(B) CONSIDERATIONS.—In designating accreditation or training requirements under this section, the Secretary shall consider, as appropriate—

(i) standards for qualifications of health care interpreters who interpret infrequently encountered languages;

(ii) standards for qualifications of health care interpreters who interpret in languages of lesser diffusion;

(iii) standards for training of interpreters; and

(iv) standards for continuing education of interpreters.

(i) GENERAL PROVISIONS.—Nothing in this section shall be construed to limit otherwise existing obligations of recipients of Federal financial assistance under title VI

of the Civil Rights Act of 1964 (42 U.S.C. 2000(d) et seq.) or any other statute.

(j) APPROPRIATIONS.—There are appropriated to carry out this section, in equal parts from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund, $16,000,000 for each fiscal year of the demonstration program.

SEC. 1223. IOM REPORT ON IMPACT OF LANGUAGE ACCESS SERVICES.

(a) IN GENERAL.—The Secretary of Health and Human Services shall enter into an arrangement with the Institute of Medicine under which the Institute will prepare and publish, not later than 3 years after the date of the enactment of this Act, a report on the impact of language access services on the health and health care of limited English proficient populations.

(b) CONTENTS.—Such report shall include—

(1) recommendations on the development and implementation of policies and practices by health care organizations and providers for limited English proficient patient populations;

(2) a description of the effect of providing language access services on quality of health care and access to care and reduced medical error; and

(3) a description of the costs associated with or savings related to provision of language access services.

SEC. 1224. DEFINITIONS.

In this subtitle:

(1) BILINGUAL.—The term ''bilingual'' with respect to an individual means a person who has sufficient degree of proficiency in two languages and can ensure effective communication can occur in both languages.

(2) COMPETENT INTERPRETER SERVICES.—The term ''competent interpreter services'' means a trans-language rendition of a spoken message in which the interpreter comprehends the source language and can speak comprehensively in the target language to convey the meaning intended in the source language. The interpreter knows health and health-related terminology and provides accurate interpretations by choosing equivalent expressions that convey the best matching and meaning to the source language and captures, to the greatest possible extent, all nuances intended in the source message.

(3) COMPETENT TRANSLATION SERVICES.—The term ''competent translation services'' means a trans-language rendition of a written document in

which the translator comprehends the source language and can write comprehensively in the target language to convey the meaning intended in the source language. The translator knows health and health-related terminology and provides accurate translations by choosing equivalent expressions that convey the best matching and meaning to the source language and captures, to the greatest possible extent, all nuances intended in the source document.

(4) EFFECTIVE COMMUNICATION.—The term ''effective communication'' means an exchange of information between the provider of health care or health care-related services and the limited English proficient recipient of such services that enables limited English proficient individuals to access, understand, and benefit from health care or health care-related services.

(5) INTERPRETING/INTERPRETATION.—The terms ''interpreting'' and ''interpretation'' mean the transmission of a spoken message from one language into another, faithfully, accurately, and objectively.

(6) HEALTH CARE SERVICES.—The term ''health care services'' means services that address physical as well as mental health conditions in all care settings.

(7) HEALTH CARE-RELATED SERVICES.—The term ''health care-related services'' means human or social services programs or activities that provide access, referrals or links to health care.

(8) LANGUAGE ACCESS.—The term ''language access'' means the provision of language services to an LEP individual designed to enhance that individual's access to, understanding of or benefit from health care or health care-related services.

(9) LANGUAGE SERVICES.—The term ''language services'' means provision of health care services directly in a non-English language, interpretation, translation, and non-English signage.

(10) LIMITED ENGLISH PROFICIENT.—The term ''limited English proficient'' or ''LEP'' with respect to an individual means an individual who speaks a primary language other than English and who cannot speak, read, write or understand the English language at a level that permits the individual to effectively communicate with clinical or nonclinical staff at an entity providing health care or health care related services.

(11) MEDICARE BENEFICIARY.—The term ''Medicare beneficiary'' means an individual entitled

to benefits under part A of title XVIII of the Social Security Act or enrolled under part B of such title.

(12) MEDICARE PROGRAM.—The term ''Medicare program'' means the programs under parts A through D of title XVIII of the Social Security Act.

(13) SERVICE PROVIDER.—The term ''service provider'' includes all suppliers, providers of services, or entities under contract to provide coverage, items or services under any part of title XVIII of the Social Security Act.

Subtitle C—Miscellaneous Improvements

SEC. 1231. EXTENSION OF THERAPY CAPS EXCEPTIONS PROCESS.

Section 1833(g)(5) of the Social Security Act (42 U.S.C. 1395l(g)(5)), as amended by section 141 of the Medicare Improvements for Patients and Providers Act of 2008 (Public Law 110–275), is amended by striking ''December 31, 2009'' and inserting ''December 31, 2011''.

SEC. 1232. EXTENDED MONTHS OF COVERAGE OF IMMUNOSUPPRESSIVE DRUGS FOR KIDNEY TRANSPLANT PATIENTS AND OTHER RENAL DIALYSIS PROVISIONS.

(a) PROVISION OF APPROPRIATE COVERAGE OF IMMUNOSUPPRESSIVE DRUGS UNDER THE MEDICARE PROGRAM FOR KIDNEY TRANSPLANT RECIPIENTS.—

(1) CONTINUED ENTITLEMENT TO IMMUNOSUPPRESSIVE DRUGS.—

(A) KIDNEY TRANSPLANT RECIPIENTS.—Section 226A(b)(2) of the Social Security Act (42 U.S.C. 426–1(b)(2)) is amended by inserting ''(except for coverage of immunosuppressive drugs under section 1861(s)(2)(J))'' before '', with the thirty-sixth month''.

(B) APPLICATION.—Section 1836 of such Act (42 U.S.C. 1395o) is amended—

(i) by striking ''Every individual who'' and inserting ''(a) IN GENERAL.—Every individual who''; and

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

''(b) SPECIAL RULES APPLICABLE TO INDIVIDUALS ONLY ELIGIBLE FOR COVERAGE OF IMMUNOSUPPRESSIVE DRUGS.—

''(1) IN GENERAL.—In the case of an individual whose eligibility for benefits under this title has ended on or after January 1, 2012, except for the coverage of immunosuppressive drugs by reason of section 226A(b)(2), the following rules shall apply:

''(A) The individual shall be deemed to be enrolled under this part for purposes of receiving coverage of such drugs.

''(B) The individual shall be responsible for providing for payment of the portion of the premium under section 1839 which is not covered under the Medicare savings program (as defined in section 1144(c)(7)) in order to receive such coverage.

''(C) The provision of such drugs shall be subject to the application of—

''(i) the deductible under section 1833(b); and

''(ii) the coinsurance amount applicable for such drugs (as determined under this part).

''(D) If the individual is an inpatient of a hospital or other entity, the individual is entitled to receive coverage of such drugs under this part.

''(2) ESTABLISHMENT OF PROCEDURES IN ORDER TO IMPLEMENT COVERAGE.—The Secretary shall establish procedures for—

''(A) identifying individuals that are entitled to coverage of immunosuppressive drugs by reason of section 226A(b)(2); and

''(B) distinguishing such individuals from individuals that are enrolled under this part for the complete package of benefits under this part.''.

(C) TECHNICAL AMENDMENT TO CORRECT DUPLICATE SUBSECTION DESIGNATION.—Subsection (c) of section 226A of such Act (42 U.S.C. 426–1), as added by section 201(a)(3)(D)(ii) of the Social Security Independence and Program Improvements Act of 1994 (Public Law 103–296; 108 Stat. 1497), is redesignated as subsection (d).

(2) EXTENSION OF SECONDARY PAYER REQUIREMENTS FOR ESRD BENEFICIARIES.—Section 1862(b)(1)(C) of such Act (42 U.S.C. 1395y(b)(1)(C)) is amended by adding at the end the following new sentence: ''With regard to immunosuppressive drugs furnished on or after the date of the enactment of the Affordable Health Care

for America Act, this subparagraph shall be applied without regard to any time limitation.''.

(b) MEDICARE COVERAGE FOR ESRD PATIENTS.—Section 1881 of such Act is further amended—

(1) in subsection (b)(14)(B)(iii), by inserting '', including oral drugs that are not the oral equivalent of an intravenous drug (such as oral phosphate binders and calcimimetics),'' after ''other drugs and biologicals'';

(2) in subsection (b)(14)(E)(ii)—

(A) in the first sentence—

(i) by striking ''a one-time election to be excluded from the phase-in'' and inserting ''an election, with respect to 2011, 2012, or 2013, to be excluded from the phase-in (or the remainder of the phase-in)''; and

(ii) by adding before the period at the end the following: ''for such year and for each subsequent year during the phase-in described in clause (i)''; and

(B) in the second sentence—

(i) by striking ''January 1, 2011'' and inserting ''the first date of such year''; and

(ii) by inserting ''and at a time'' after ''form and manner''; and

(3) in subsection (h)(4)(E), by striking ''lesser'' and inserting ''greater''.

SEC. 1233. VOLUNTARY ADVANCE CARE PLANNING CONSULTATION.

(a) IN GENERAL.—Section 1861 of the Social Security Act (42 U.S.C. 1395x) is amended—

(1) in subsection (s)(2)—

(A) by striking ''and'' at the end of subparagraph (DD);

(B) by adding ''and'' at the end of subparagraph (EE); and

(C) by adding at the end the following new subparagraph:

''(FF) voluntary advance care planning consultation (as defined in subsection (hhh)(1));''; and

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

''Voluntary Advance Care Planning Consultation

''(hhh)(1) Subject to paragraphs (3) and (4), the term 'voluntary advance care planning consultation' means an optional consultation between the individual and a practitioner described in paragraph (2) regarding ad-

vance care planning. Such consultation may include the following, as specified by the Secretary:

''(A) An explanation by the practitioner of advance care planning, including a review of key questions and considerations, advance directives (including living wills and durable powers of attorney) and their uses.

''(B) An explanation by the practitioner of the role and responsibilities of a health care proxy and of the continuum of end-of-life services and supports available, including palliative care and hospice, and benefits for such services and supports that are available under this title.

''(C) An explanation by the practitioner of physician orders regarding life sustaining treatment or similar orders, in States where such orders or similar orders exist.

''(2) A practitioner described in this paragraph is—

''(A) a physician (as defined in subsection (r)(1)); and

''(B) another health care professional (as specified by the Secretary and who has the authority under State law to sign orders for life sustaining treatments, such as a nurse practitioner or physician assistant).

''(3) An individual may receive the voluntary advance care planning care planning consultation provided for under this subsection no more than once every 5 years unless there is a significant change in the health or health-related condition of the individual.

''(4) For purposes of this section, the term 'order regarding life sustaining treatment' means, with respect to an individual, an actionable medical order relating to the treatment of that individual that effectively communicates the individual's preferences regarding life sustaining treatment, is signed and dated by a practitioner, and is in a form that permits it to be followed by health care professionals across the continuum of care.''.

(b) CONSTRUCTION.—The voluntary advance care planning consultation described in section 1861(hhh) of the Social Security Act, as added by subsection (a), shall be completely optional. Nothing in this section shall—

(1) require an individual to complete an advance directive, an order for life sustaining treatment, or other advance care planning document;

(2) require an individual to consent to restrictions on the amount, duration, or scope of medical benefits an individual is entitled to receive under this title; or

(3) encourage the promotion of suicide or assisted suicide.

(c) PAYMENT.—Section 1848(j)(3) of such Act (42 U.S.C. 1395w-4(j)(3)) is amended by inserting ''(2)(FF),'' after ''(2)(EE),''.

(d) FREQUENCY LIMITATION.—Section 1862(a) of such Act (42 U.S.C. 1395y(a)) is amended—

(1) in paragraph (1)—

(A) in subparagraph (N), by striking ''and'' at the end;

(B) in subparagraph (O) by striking the semicolon at the end and inserting '', and''; and

(C) by adding at the end the following new subparagraph:

''(P) in the case of voluntary advance care planning consultations (as defined in paragraph (1) of section 1861(hhh)), which are performed more frequently than is covered under such section;''; and

(2) in paragraph (7), by striking ''or (K)'' and inserting ''(K), or (P)''.

(e) EFFECTIVE DATE.—The amendments made by this section shall apply to consultations furnished on or after January 1, 2011.

SEC. 1234. PART B SPECIAL ENROLLMENT PERIOD AND WAIVER OF LIMITED ENROLLMENT PENALTY FOR TRICARE BENEFICIARIES.

(a) PART B SPECIAL ENROLLMENT PERIOD.—

(1) IN GENERAL.—Section 1837 of the Social Security Act (42 U.S.C. 1395p) is amended by adding at the end the following new subsection:

''(l)(1) In the case of any individual who is a covered beneficiary (as defined in section 1072(5) of title 10, United States Code) at the time the individual is entitled to hospital insurance benefits under part A under section 226(b) or section 226A and who is eligible to enroll but who has elected not to enroll (or to be deemed enrolled) during the individual's initial enrollment period, there shall be a special enrollment period described in paragraph (2).

''(2) The special enrollment period described in this paragraph, with respect to an individual, is the 12-month period beginning on the day after the last day of the initial enrollment period of the individual or, if later, the 12-month period beginning with the month the individual is notified of enrollment under this section.

''(3) In the case of an individual who enrolls during the special enrollment period provided under paragraph (1), the coverage period under this part shall begin on the first day of the month in which the individual enrolls or,

at the option of the individual, on the first day of the second month following the last month of the individual's initial enrollment period.

''(4) The Secretary of Defense shall establish a method for identifying individuals described in paragraph (1) and providing notice to them of their eligibility for enrollment during the special enrollment period described in paragraph (2).''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to elections made on or after the date of the enactment of this Act.

(b) WAIVER OF INCREASE OF PREMIUM.—

(1) IN GENERAL.—Section 1839(b) of the Social Security Act (42 U.S.C. 1395r(b)) is amended by striking ''section 1837(i)(4)'' and inserting ''subsection (i)(4) or (l) of section 1837''.

(2) EFFECTIVE DATE.—

(A) IN GENERAL.—The amendment made by paragraph (1) shall apply with respect to elections made on or after the date of the enactment of this Act.

(B) REBATES FOR CERTAIN DISABLED AND ESRD BENEFICIARIES.—

(i) IN GENERAL.—With respect to premiums for months on or after January

2005 and before the month of the enactment of this Act, no increase in the premium shall be effected for a month in the case of any individual who is a covered beneficiary (as defined in section 1072(5) of title 10, United States Code) at the time the individual is entitled to hospital insurance benefits under part A of title XVIII of the Social Security Act under section 226(b) or 226A of such Act, and who is eligible to enroll, but who has elected not to enroll (or to be deemed enrolled), during the individual's initial enrollment period, and who enrolls under this part within the 12-month period that begins on the first day of the month after the month of notification of entitlement under this part.

(ii) CONSULTATION WITH DEPARTMENT OF DEFENSE.—The Secretary of Health and Human Services shall consult with the Secretary of Defense in identifying individuals described in this paragraph.

(iii) REBATES.—The Secretary of Health and Human Services shall establish

a method for providing rebates of premium increases paid for months on or after January 1, 2005, and before the month of the enactment of this Act for which a penalty was applied and collected.

SEC. 1235. EXCEPTION FOR USE OF MORE RECENT TAX YEAR IN CASE OF GAINS FROM SALE OF PRIMARY RESIDENCE IN COMPUTING PART B INCOME-RELATED PREMIUM.

(a) IN GENERAL.—Section 1839(i)(4)(C)(ii)(II) of the Social Security Act (42 U.S.C. 1395r(i)(4)(C)(ii)(II)) is amended by inserting ''sale of primary residence,'' after ''divorce of such individual,''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to premiums and payments for years beginning with 2011.

SEC. 1236. DEMONSTRATION PROGRAM ON USE OF PATIENT DECISIONS AIDS.

(a) IN GENERAL.—The Secretary of Health and Human Services , acting through the Center for Medicare and Medicaid Innovation established under section 1115A of the Social Security Act (as added by section 1907) and consistent with the applicable provisions of such section, shall establish a shared decision making demonstration program (in this subsection referred to as the ''program'')

under the Medicare program using patient decision aids to meet the objective of improving the understanding by Medicare beneficiaries of their medical treatment options, as compared to comparable Medicare beneficiaries who do not participate in a shared decision making process using patient decision aids.

(b) SITES.—

(1) ENROLLMENT.—The Secretary shall enroll in the program not more than 30 eligible providers who have experience in implementing, and have invested in the necessary infrastructure to implement, shared decision making using patient decision aids.

(2) APPLICATION.—An eligible provider seeking to participate in the program shall submit to the Secretary an application at such time and containing such information as the Secretary may require.

(3) PREFERENCE.—In enrolling eligible providers in the program, the Secretary shall give preference to eligible providers that—

(A) have documented experience in using patient decision aids for the conditions identified by the Secretary and in using shared decision making;

(B) have the necessary information technology infrastructure to collect the information

required by the Secretary for reporting purposes; and

(C) are trained in how to use patient decision aids and shared decision making.

(c) FOLLOW-UP COUNSELING VISIT.—

(1) IN GENERAL.—An eligible provider participating in the program shall routinely schedule Medicare beneficiaries for a counseling visit after the viewing of such a patient decision aid to answer any questions the beneficiary may have with respect to the medical care of the condition involved and to assist the beneficiary in thinking through how their preferences and concerns relate to their medical care.

(2) PAYMENT FOR FOLLOW-UP COUNSELING VISIT.—The Secretary shall establish procedures for making payments for such counseling visits provided to Medicare beneficiaries under the program. Such procedures shall provide for the establishment—

(A) of a code (or codes) to represent such services; and

(B) of a single payment amount for such service that includes the professional time of the health care provider and a portion of the reasonable costs of the infrastructure of the eli-

gible provider such as would be made under the applicable payment systems to that provider for similar covered services.

(d) COSTS OF AIDS.—An eligible provider participating in the program shall be responsible for the costs of selecting, purchasing, and incorporating such patient decision aids into the provider's practice, and reporting data on quality and outcome measures under the program.

(e) FUNDING.—The Secretary shall provide for the transfer from the Federal Supplementary Medical Insurance Trust Fund established under section 1841 of the Social Security Act (42 U.S.C. 1395t) of such funds as are necessary for the costs of carrying out the program.

(f) WAIVER AUTHORITY.—The Secretary may waive such requirements of titles XI and XVIII of the Social Security Act (42 U.S.C. 1301 et seq. and 1395 et seq.) as may be necessary for the purpose of carrying out the program.

(g) REPORT.—Not later than 12 months after the date of completion of the program, the Secretary shall submit to Congress a report on such program, together with recommendations for such legislation and administrative action as the Secretary determines to be appropriate. The final report shall include an evaluation of the impact of the use of the program on health quality, utilization of

health care services, and on improving the quality of life of such beneficiaries.

(h) DEFINITIONS.—In this section:

(1) ELIGIBLE PROVIDER.—The term ''eligible provider'' means the following:

(A) A primary care practice.

(B) A specialty practice.

(C) A multispecialty group practice.

(D) A hospital.

(E) A rural health clinic.

(F) A Federally qualified health center (as defined in section 1861(aa)(4) of the Social Security Act (42 U.S.C. 1395x(aa)(4)).

(G) An integrated delivery system.

(H) A State cooperative entity that includes the State government and at least one other health care provider which is set up for the purpose of testing shared decision making and patient decision aids.

(2) PATIENT DECISION AID.—The term ''patient decision aid'' means an educational tool (such as the Internet, a video, or a pamphlet) that helps patients (or, if appropriate, the family caregiver of the patient) understand and communicate their beliefs and preferences related to their treatment op-

tions, and to decide with their health care provider what treatments are best for them based on their treatment options, scientific evidence, circumstances, beliefs, and preferences.

(3) SHARED DECISION MAKING.—The term ''shared decision making'' means a collaborative process between patient and clinician that engages the patient in decision making, provides patients with information about trade-offs among treatment options, and facilitates the incorporation of patient preferences and values into the medical plan.

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

SEC. 1301. ACCOUNTABLE CARE ORGANIZATION PILOT PROGRAM.

Title XVIII of the Social Security Act is amended by inserting after section 1866D, as added by section 1152(f), the following new section:

''ACCOUNTABLE CARE ORGANIZATION PILOT PROGRAM

''SEC. 1866E. (a) ESTABLISHMENT.—

''(1) 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 incen-

tive 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 (e)) by qualifying accountable care organizations (as defined in subsection (b)(1)) in order to—

''(A) promote accountability for a patient population and coordinate items and services under parts A and B (and may include Part D, if the Secretary determines appropriate);

''(B) encourage investment in infrastructure and redesigned care processes for high quality and efficient service delivery; and

''(C) reward physician practices and other physician organizational models for the provision of high quality and efficient health care services.

''(2) SCOPE.—The Secretary shall set specific goals for the number of accountable care organizations, participating practitioners, and patients served in the initial tests under the pilot program to ensure that the pilot program is of sufficient size and scope to—

''(A) test the approach involved in a variety of settings, including urban, rural, and underserved areas; and

''(B) subject to subsection (g)(1), disseminate such approach rapidly on a national basis.

To the extent that the Secretary finds a qualifying accountable care organization model to be successful in improving quality and reducing costs, the Secretary shall seek to implement such models on as large a geographic scale as practical and economical.

''(b) QUALIFYING ACCOUNTABLE CARE ORGANIZATIONS (ACOS).—

''(1) QUALIFYING ACO DEFINED.—In this section:

''(A) IN GENERAL.—The terms 'qualifying accountable care organization' and 'qualifying ACO' mean a group of physicians or other physician organizational model (as defined in subparagraph (D)) that—

''(i) is organized at least in part for the purpose of providing physicians' services; and

''(ii) meets such criteria as the Secretary determines to be appropriate to participate in the pilot program, including the criteria specified in paragraph (2).

''(B) INCLUSION OF OTHER PROVIDERS OF SERVICES AND SUPPLIERS.—Nothing in this

subsection shall be construed as preventing a qualifying ACO from including a hospital or any other provider of services or supplier furnishing items or services for which payment may be made under this title that is affiliated with the ACO under an arrangement structured so that such provider or supplier participates in the pilot program and shares in any incentive payments under the pilot program.

''(C) PHYSICIAN.—The term 'physician' includes, except as the Secretary may otherwise provide, any individual who furnishes services for which payment may be made as physicians' services under this title.

''(D) OTHER PHYSICIAN ORGANIZATIONAL MODEL.—The term 'other physician organization model' means, with respect to a qualifying ACO any model of organization under which physicians enter into agreements with other providers of services for the purposes of participation in the pilot program in order to provide high quality and efficient health care services and share in any incentive payments under such program

''(E) OTHER SERVICES.—Nothing in this paragraph shall be construed as preventing a qualifying ACO from furnishing items or services, for which payment may not be made under this title, for purposes of achieving performance goals under the pilot program.

''(2) QUALIFYING CRITERIA.—The following are criteria described in this paragraph for an organized group of physicians to be a qualifying ACO:

''(A) The group has a legal structure that would allow the group to receive and distribute incentive payments under this section.

''(B) The group includes a sufficient number of primary care physicians (regardless of specialty) for the applicable beneficiaries for whose care the group is accountable (as determined by the Secretary).

''(C) The group reports on quality measures in such form, manner, and frequency as specified by the Secretary (which may be for the group, for providers of services and suppliers, or both).

''(D) The group reports to the Secretary (in a form, manner and frequency as specified by the Secretary) such data as the Secretary

determines appropriate to monitor and evaluate the pilot program.

''(E) The group provides notice to applicable beneficiaries regarding the pilot program (as determined appropriate by the Secretary).

''(F) The group contributes to a best practices network or website, that shall be maintained by the Secretary for the purpose of sharing strategies on quality improvement, care coordination, and efficiency that the groups believe are effective.

''(G) The group utilizes patient-centered processes of care, including those that emphasize patient and caregiver involvement in planning and monitoring of ongoing care management plan.

''(H) The group meets other criteria determined to be appropriate by the Secretary.

''(c) SPECIFIC PAYMENT INCENTIVE MODELS.—The specific payment incentive models described in this subsection are the following:

''(1) PERFORMANCE TARGET MODEL.—Under the performance target model under this paragraph (in this paragraph referred to as the 'performance target model'):

''(A) IN GENERAL.—A qualifying ACO qualifies to receive an incentive payment if expenditures for items and services for applicable beneficiaries are less than a target spending level or a target rate of growth. The incentive payment shall be made only if savings are greater than would result from normal variation in expenditures for items and services covered under parts A and B (and may include Part D, if the Secretary determines appropriate).

''(B) COMPUTATION OF PERFORMANCE TARGET.—

''(i) IN GENERAL.—The Secretary shall establish a performance target for each qualifying ACO comprised of a base amount (described in clause (ii)) increased to the current year by an adjustment factor (described in clause (iii)). Such a target may be established on a per capita basis or adjusted for risk, as the Secretary determines to be appropriate.

''(ii) BASE AMOUNT.—For purposes of clause (i), the base amount in this subparagraph is equal to the average total payments (or allowed charges) under parts

A and B (and may include part D, if the Secretary determines appropriate) for applicable beneficiaries for whom the qualifying ACO furnishes items and services in a base period determined by the Secretary. Such base amount may be determined on a per capita basis or adjusted for risk.

''(iii) ADJUSTMENT FACTOR.—For purposes of clause (i), the adjustment factor in this clause may equal an annual per capita amount that reflects changes in expenditures from the period of the base amount to the current year that would represent an appropriate performance target for applicable beneficiaries (as determined by the Secretary).

''(iv) REBASING.—Under this model the Secretary shall periodically rebase the base expenditure amount described in clause (ii).

''(C) MEETING TARGET.—

''(i) IN GENERAL.—Subject to clause (ii), a qualifying ACO that meets or exceeds annual quality and performance targets for a year shall receive an incentive

payment for such year equal to a portion (as determined appropriate by the Secretary) of the amount by which payments under this title for such year are estimated to be below the performance target for such year, as determined by the Secretary. The Secretary may establish a cap on incentive payments for a year for a qualifying ACO.

''(ii) LIMITATION.— The Secretary shall limit incentive payments to each qualifying ACO under this paragraph as necessary to ensure that the aggregate expenditures with respect to applicable beneficiaries for such ACOs under this title (inclusive of incentive payments described in this subparagraph) do not exceed the amount that the Secretary estimates would be expended for such ACO for such beneficiaries if the pilot program under this section were not implemented.

''(D) REPORTING AND OTHER REQUIREMENTS.—In carrying out such model, the Secretary may (as the Secretary determines to be appropriate) incorporate reporting require-

ments, incentive payments, and penalties related to the physician quality reporting initiative (PQRI), electronic prescribing, electronic health records, and other similar initiatives under section 1848, and may use alternative criteria than would otherwise apply under such section for determining whether to make such payments. The incentive payments described in this subparagraph shall not be included in the limit described in subparagraph (C)(ii) or in the performance target model described in this paragraph.

''(2) PARTIAL CAPITATION MODEL.—

''(A) IN GENERAL.—Subject to subparagraph (B), a partial capitation model described in this paragraph (in this paragraph referred to as a 'partial capitation model') is a model in which a qualifying ACO would be at financial risk for some, but not all, of the items and services covered under parts A and B (and may include part D, if the Secretary determines appropriate), such as at risk for some or all physicians' services or all items and services under part B. The Secretary may limit a partial capitation model to ACOs that are highly integrated

systems of care and to ACOs capable of bearing risk, as determined to be appropriate by the Secretary.

''(B) NO ADDITIONAL PROGRAM EXPENDITURES.—Payments to a qualifying ACO for items and services under this title for applicable beneficiaries for a year under the partial capitation model shall be established in a manner that does not result in spending more for such ACO for such beneficiaries than would otherwise be expended for such ACO for such beneficiaries for such year if the pilot program were not implemented, as estimated by the Secretary.

''(3) OTHER PAYMENT MODELS.—

''(A) IN GENERAL.—Subject to subparagraph (B), the Secretary may develop other payment models that meet the goals of this pilot program to improve quality and efficiency.

''(B) NO ADDITIONAL PROGRAM EXPENDITURES.—Subparagraph (B) of paragraph (2) shall apply to a payment model under subparagraph (A) in a similar manner as such subparagraph (B) applies to the payment model under paragraph (2).

''(d) ANNUAL QUALITY TARGETS.—

''(1) IN GENERAL.—The Secretary shall establish annual quality targets that qualifying ACOs must meet to receive incentive payments, operate at financial risk, or otherwise participate in alternative financing models under this section. The Secretary shall establish a process for developing annual targets based on ACO reporting of multiple quality measures. In selecting measures the Secretary shall—

''(A) for years one and two of each ACOs participation in the pilot program established by this section, require reporting of a starter set of measures focused on clinical care, care coordination and patient experience of care; and

''(B) for each subsequent year, require reporting of a more comprehensive set of clinical outcomes measures, care coordination measures and patient experience of care measures.

''(2) MEASURE SELECTION.—To the extent feasible, the Secretary shall select measures that reflect national priorities for quality improvement and patient-centered care consistent with the measures developed under section 1192(c)(1).

''(e) APPLICABLE BENEFICIARIES.—

''(1) IN GENERAL.—In this section, the term 'applicable beneficiary' means, with respect to a qualifying ACO, an individual who—

''(A) is enrolled under part B and entitled to benefits under part A;

''(B) is not enrolled in a Medicare Advantage plan under part C or a PACE program under section 1894; and

''(C) meets such other criteria as the Secretary determines appropriate, which may include criteria relating to frequency of contact with physicians in the ACO

''(2) FOLLOWING APPLICABLE BENEFICIARIES.—The Secretary may monitor data on expenditures and quality of services under this title after an applicable beneficiary discontinues receiving services under this title through a qualifying ACO.

''(f) IMPLEMENTATION.—

''(1) STARTING DATE.—The pilot program shall begin no later than January 1, 2012. An agreement with a qualifying ACO under the pilot program may cover a multi-year period of between 3 and 5 years.

''(2) WAIVER.—The Secretary may waive such provisions of this title (including section 1877) and

title XI in the manner the Secretary determines necessary in order implement the pilot program.

''(3) PERFORMANCE RESULTS REPORTS.—The Secretary shall report performance results to qualifying ACOs under the pilot program at least annually.

''(4) LIMITATIONS ON REVIEW.—There shall be no administrative or judicial review under section 1869, section 1878, or otherwise of—

''(A) the elements, parameters, scope, and duration of the pilot program;

''(B) the selection of qualifying ACOs for the pilot program;

''(C) the establishment of targets, measurement of performance, determinations with respect to whether savings have been achieved and the amount of savings;

''(D) determinations regarding whether, to whom, and in what amounts incentive payments are paid; and

''(E) decisions about the extension of the program under subsection (h), expansion of the program under subsection (i) or extensions under subsections (j) or (k).

''(5) ADMINISTRATION.—Chapter 35 of title 44, United States Code shall not apply to this section.

''(g) EVALUATION; MONITORING.—

''(1) IN GENERAL.—The Secretary shall evaluate the payment incentive model for each qualifying ACO under the pilot program to assess impacts on beneficiaries, providers of services, suppliers and the program under this title. The Secretary shall make such evaluation publicly available within 60 days of the date of completion of such report.

''(2) MONITORING.—The Inspector General of the Department of Health and Human Services shall provide for monitoring of the operation of ACOs under the pilot program with regard to violations of section 1877 (popularly known as the 'Stark law').

''(h) EXTENSION OF PILOT AGREEMENT WITH SUCCESSFUL ORGANIZATIONS.—

''(1) REPORTS TO CONGRESS.—Not later than 2 years after the date the first agreement is entered into under this section, and biennially thereafter for six years, the Secretary shall submit to Congress and make publicly available a report on the use of ACO payment models under the pilot program. Each report shall address the impact of the use of those

models on expenditures, access, and quality under this title.

''(2) EXTENSION.—Subject to the report provided under paragraph (1), with respect to a qualifying ACO, the Secretary may extend the duration of the agreement for such ACO under the pilot program as the Secretary determines appropriate if—

''(A) the ACO receives incentive payments with respect to any of the first 4 years of the pilot agreement and is consistently meeting quality standards or

''(B) the ACO is consistently exceeding quality standards and is not increasing spending under the program.

''(3) TERMINATION.—The Secretary may terminate an agreement with a qualifying ACO under the pilot program if such ACO did not receive incentive payments or consistently failed to meet quality standards in any of the first 3 years under the program.

''(i) EXPANSION TO ADDITIONAL ACOS.—

''(1) TESTING AND REFINEMENT OF PAYMENT INCENTIVE MODELS.—Subject to the evaluation described in subsection (g), the Secretary may enter into agreements under the pilot program with addi-

tional qualifying ACOs to further test and refine payment incentive models with respect to qualifying ACOs.

''(2) EXPANDING USE OF SUCCESSFUL MODELS TO PROGRAM IMPLEMENTATION.—

''(A) IN GENERAL.—Subject to subparagraph (B), the Secretary may issue regulations to implement, on a permanent basis, 1 or more models if, and to the extent that, such models are beneficial to the program under this title, as determined by the Secretary.

''(B) CERTIFICATION.—The Chief Actuary of the Centers for Medicare & Medicaid Services shall certify that 1 or more of such models described in subparagraph (A) would result in estimated spending that would be less than what spending would otherwise be estimated to be in the absence of such expansion.

''(j) TREATMENT OF PHYSICIAN GROUP PRACTICE DEMONSTRATION.—

''(1) EXTENSION.—The Secretary may enter in to an agreement with a qualifying ACO under the demonstration under section 1866A, subject to rebasing and other modifications deemed appropriate

by the Secretary, until the pilot program under this section is operational.

''(2) TRANSITION.—For purposes of extension of an agreement with a qualifying ACO under subsection (h)(2), the Secretary shall treat receipt of an incentive payment for a year by an organization under the physician group practice demonstration pursuant to section 1866A as a year for which an incentive payment is made under such subsection, as long as such practice group practice organization meets the criteria under subsection (b)(2).

''(k) ADDITIONAL PROVISIONS.—

''(1) AUTHORITY FOR SEPARATE INCENTIVE ARRANGEMENTS.—The Secretary may create separate incentive arrangements (including using multiple years of data, varying thresholds, varying shared savings amounts, and varying shared savings limits) for different categories of qualifying ACOs to reflect variation in average annual attributable expenditures and other matters the Secretary deems appropriate.

''(2) ENCOURAGEMENT OF PARTICIPATION OF SMALLER ORGANIZATIONS.—In order to encourage the participation of smaller accountable care organizations under the pilot program, the Secretary may

limit a qualifying ACO's exposure to high cost patients under the program.

''(3) INVOLVEMENT IN PRIVATE PAYER AND OTHER THIRD PARTY ARRANGEMENTS.—The Secretary may give preference to ACOs who are participating in similar arrangements with other payers.

''(4) ANTIDISCRIMINATION LIMITATION.—The Secretary shall not enter into an agreement with an entity to provide health care items or services under the pilot program, or with an entity to administer the program, unless such entity guarantees that it will not deny, limit, or condition the coverage or provision of benefits under the program, for individuals eligible to be enrolled under such program, based on any health status-related factor described in section 2702(a)(1) of the Public Health Service Act.

''(5) FUNDING.—For purposes of administering and carrying out the pilot program, other than for payments for items and services furnished under this title and incentive payments under subsection (c)(1), in addition to funds otherwise appropriated, there are appropriated to the Secretary for the Center for Medicare & Medicaid Services Program Management Account $25,000,000 for each of fiscal years 2010 through 2014 and $20,000,000 for fiscal year 2015.

Amounts appropriated under this paragraph for a fiscal year shall be available until expended.

''(6) NO DUPLICATION IN PAYMENTS TO PHYSICIANS IN MULTIPLE PILOTS.—The Secretary shall not make payments under this section to any physician group that is paid under section 1866F (relating to medical homes) or section 1866G (relating to independence at home).''.

SEC. 1302. MEDICAL HOME PILOT PROGRAM.

(a) IN GENERAL.—Title XVIII of the Social Security Act is amended by inserting after section 1866E, as inserted by section 1301, the following new section:

''MEDICAL HOME PILOT PROGRAM

''SEC. 1866F. (a) ESTABLISHMENT AND MEDICAL HOME MODELS.—

''(1) ESTABLISHMENT OF PILOT PROGRAM.—The Secretary shall establish a medical home pilot program (in this section referred to as the 'pilot program') for the purpose of evaluating the feasibility and advisability of reimbursing qualified patient-centered medical homes for furnishing medical home services (as defined under subsection (b)(1)) to beneficiaries (as defined in subsection (b)(4)) and to targeted high need beneficiaries (as defined in subsection (c)(1)(C)).

''(2) SCOPE.—Subject to subsection (g), the Secretary shall set specific goals for the number of practices and communities, and the number of patients served, under the pilot program in the initial tests to ensure that the pilot program is of sufficient size and scope to—

''(A) test the approach involved in a variety of settings, including urban, rural, and underserved areas; and

''(B) subject to subsection (e)(1), disseminate such approach rapidly on a national basis.

To the extent that the Secretary finds a medical home model to be successful in improving quality and reducing costs, the Secretary shall implement such model on as large a geographic scale as practical and economical.

''(3) MODELS OF MEDICAL HOMES IN THE PILOT PROGRAM.—The pilot program shall evaluate each of the following medical home models:

''(A) INDEPENDENT PATIENT-CENTERED MEDICAL HOME MODEL.—Independent patient-centered medical home model under subsection (c).

''(B) COMMUNITY-BASED MEDICAL HOME MODEL.—Community-based medical home model under subsection (d).

''(4) PARTICIPATION OF NURSE PRACTITIONERS AND PHYSICIAN ASSISTANTS.—

''(A) Nothing in this section shall be construed as preventing a nurse practitioner from leading a patient centered medical home so long as—

''(i) all the requirements of this section are met; and

''(ii) the nurse practitioner is acting in a manner that is consistent with State law.

''(B) Nothing in this section shall be construed as preventing a physician assistant from participating in a patient centered medical home so long as—

''(i) all the requirements of this section are met; and

''(ii) the physician assistant is acting in a manner that is consistent with State law.

''(b) DEFINITIONS.—For purposes of this section:

''(1) PATIENT-CENTERED MEDICAL HOME SERVICES.—The term 'patient-centered medical home services' means services that—

''(A) provide beneficiaries with direct and ongoing access to a primary care or principal care physician or nurse practitioner who accepts responsibility for providing first contact, continuous and comprehensive care to such beneficiary;

''(B) coordinate the care provided to a beneficiary by a team of individuals at the practice level across office, provider of services, and home settings led by a primary care or principal care physician or nurse practitioner, as needed and appropriate;

''(C) provide for all the patient's health care needs or take responsibility for appropriately arranging care with other qualified physicians or providers for all stages of life;

''(D) provide continuous access to care and communication with participating beneficiaries;

''(E) provide support for patient self-management, proactive and regular patient monitoring, support for family caregivers, use pa-

tient-centered processes, and coordination with community resources;

''(F) integrate readily accessible, clinically useful information on participating patients that enables the practice to treat such patients comprehensively and systematically; and

''(G) implement evidence-based guidelines and apply such guidelines to the identified needs of beneficiaries over time and with the intensity needed by such beneficiaries.

''(2) PRIMARY CARE.—The term 'primary care' means health care that is provided by a physician, nurse practitioner, or physician assistant who practices in the field of family medicine, general internal medicine, geriatric medicine, or pediatric medicine.

''(3) PRINCIPAL CARE.—The term 'principal care' means integrated, accessible health care that is provided by a physician who is a medical specialist or subspecialist that addresses the majority of the personal health care needs of patients with chronic conditions requiring the specialist's or subspecialist's expertise, and for whom the specialist or subspecialist assumes care management.

''(4) BENEFICIARIES.—The term 'beneficiaries' means, with respect to a qualifying medical home, an individual who—

''(A) is enrolled under part B and entitled to benefits under part A;

''(B) is not enrolled in a Medicare Advantage plan under part C or a PACE program under section 1894; and

''(C) meets such other criteria as the Secretary determines appropriate.

''(c) INDEPENDENT PATIENT-CENTERED MEDICAL HOME MODEL.—

''(1) IN GENERAL.—

''(A) PAYMENT AUTHORITY.—Under the independent patient-centered medical home model under this subsection, the Secretary shall make payments for medical home services furnished by an independent patient-centered medical home (as defined in subparagraph (B)) pursuant to paragraph (3) for targeted high need beneficiaries (as defined in subparagraph (C)).

''(B) INDEPENDENT PATIENT-CENTERED MEDICAL HOME DEFINED.—In this section, the term 'independent patient-centered medical

home' means a physician-directed or nurse-practitioner-directed practice that is qualified under paragraph (2) as—

"(i) providing beneficiaries with patient-centered medical home services; and

"(ii) meets such other requirements as the Secretary may specify.

"(C) TARGETED HIGH NEED BENEFICIARY DEFINED.—For purposes of this subsection, the term 'targeted high need beneficiary' means a beneficiary who, based on a risk score as specified by the Secretary, is generally within the upper 50th percentile of Medicare beneficiaries.

"(D) BENEFICIARY ELECTION TO PARTICIPATE.—The Secretary shall determine an appropriate method of ensuring that beneficiaries have agreed to participate in the pilot program.

"(E) IMPLEMENTATION.—The pilot program under this subsection shall begin no later than 12 months after the date of the enactment of this section and shall operate for 5 years.

"(2) QUALIFICATION PROCESS FOR PATIENT-CENTERED MEDICAL HOMES.—The Secretary shall establish a process for practices to qualify as medical homes.

''(3) PAYMENT.—

''(A) ESTABLISHMENT OF METHODOLOGY.—The Secretary shall establish a methodology for the payment for medical home services furnished by independent patient-centered medical homes. Under such methodology, the Secretary shall adjust payments to medical homes based on beneficiary risk scores to ensure that higher payments are made for higher risk beneficiaries.

''(B) PER BENEFICIARY PER MONTH PAYMENTS.—Under such payment methodology, the Secretary shall pay independent patient-centered medical homes a monthly fee for each targeted high need beneficiary who consents to receive medical home services through such medical home.

''(C) PROSPECTIVE PAYMENT.—The fee under subparagraph (B) shall be paid on a prospective basis.

''(D) AMOUNT OF PAYMENT.—In determining the amount of such fee, the Secretary shall consider the following:

''(i) The clinical work and practice expenses involved in providing the medical

home services provided by the independent patient-centered medical home (such as providing increased access, care coordination, population disease management, and teaching self-care skills for managing chronic illnesses) for which payment is not made under this title as of the date of the enactment of this section.

''(ii) Allow for differential payments based on capabilities of the independent patient-centered medical home.

''(iii) Use appropriate risk-adjustment in determining the amount of the per beneficiary per month payment under this paragraph in a manner that ensures that higher payments are made for higher risk beneficiaries.

''(4) ENCOURAGING PARTICIPATION OF VARIETY OF PRACTICES.—The pilot program under this subsection shall be designed to include the participation of physicians in practices with fewer than 10 full-time equivalent physicians, as well as physicians in larger practices, particularly in underserved and rural areas, as well as federally qualified health centers, and rural health centers.

"(d) COMMUNITY-BASED MEDICAL HOME MODEL.—

"(1) IN GENERAL.—

"(A) AUTHORITY FOR PAYMENTS.—Under the community-based medical home model under this subsection (in this section referred to as the 'CBMH model'), the Secretary shall make payments for the furnishing of medical home services by a community-based medical home (as defined in subparagraph (B)) pursuant to paragraph (5)(B) for beneficiaries.

"(B) COMMUNITY-BASED MEDICAL HOME DEFINED.—In this section, the term 'community-based medical home' means a nonprofit community-based or State-based organization or a State that is certified under paragraph (2) as meeting the following requirements:

"(i) The organization provides beneficiaries with medical home services.

"(ii) The organization provides medical home services under the supervision of and in close collaboration with the primary care or principal care physician, nurse practitioner, or physician assistant designated by the beneficiary as his or her community-based medical home provider.

''(iii) The organization employs community health workers, including nurses or other non-physician practitioners, lay health workers, or other persons as determined appropriate by the Secretary, that assist the primary or principal care physician, nurse practitioner, or physician assistant in chronic care management activities such as teaching self-care skills for managing chronic illnesses, transitional care services, care plan setting, nutritional counseling, medication therapy management services for patients with multiple chronic diseases, or help beneficiaries access the health care and community-based resources in their local geographic area.

''(iv) The organization meets such other requirements as the Secretary may specify.

''(2) QUALIFICATION PROCESS FOR COMMUNITY-BASED MEDICAL HOMES.—The Secretary shall establish a process to provide for the review and qualification of community-based medical homes pursuant to criteria established by the Secretary.

''(3) DURATION.—The pilot program for community-based medical homes under this subsection shall start no later than 2 years after the date of the enactment of this section. Each demonstration site under the pilot program shall operate for a period of up to 5 years after the initial implementation phase, without regard to the receipt of a initial implementation funding under paragraph (6).

''(4) PREFERENCE.—In selecting sites for the CBMH model, the Secretary shall give preference to applications which seek to eliminate health disparities, as defined in section 3171 of the Public Health Service Act and may give preference to any of the following:

''(A) Applications that propose to coordinate health care items and services under this title for chronically ill beneficiaries who rely, for primary care, on small physician or nurse practitioner practices, federally qualified health centers, rural health clinics, or other settings with limited resources and scope of services.

''(B) Applications that include other third-party payors that furnish medical home services for chronically ill patients covered by such third-party payors.

''(C) Applications from States that propose to use the medical home model to coordinate health care services for—

''(i) individuals enrolled under this title;

''(ii) individuals enrolled under title XIX; and

''(iii) full-benefit dual eligible individuals (as defined in section 1935(c)(6)),

with chronic diseases across a variety of health care settings.

''(5) PAYMENTS.—

''(A) ESTABLISHMENT OF METHODOLOGY.—The Secretary shall establish a methodology for the payment for medical home services furnished under the CBMH model.

''(B) PER BENEFICIARY PER MONTH PAYMENTS.—Under such payment methodology, the Secretary shall make two separate monthly payments for each beneficiary who consents to receive medical home services through such medical home, as follows:

''(i) PAYMENT TO COMMUNITY-BASED ORGANIZATION.—One monthly payment to

a community-based or State-based organization or State.

''(ii) PAYMENT TO PRIMARY OR PRINCIPAL CARE PRACTICE.—One monthly payment to the primary or principal care practice for such beneficiary.

''(C) PROSPECTIVE PAYMENT.—The payments under subparagraph (B) shall be paid on a prospective basis.

''(D) AMOUNT OF PAYMENT.—In determining the amount of such payment under subparagraph (B), the Secretary shall consider the following:

''(i) The clinical work and practice expenses involved in providing the medical home services provided by the primary or principal care practice (such as providing increased access, care coordination, care planning, population disease management, and teaching self-care skills for managing chronic illnesses) for which payment is not made under this title as of the date of the enactment of this section.

''(ii) Use appropriate risk-adjustment in determining the amount of the per bene-

ficiary per month payment under this paragraph.

"(iii) In the case of the models described in subparagraphs (B) and (C) of paragraph (4), the Secretary may determine an appropriate payment amount.

"(6) INITIAL IMPLEMENTATION FUNDING.—The Secretary may make available initial implementation funding to a non-profit 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. The Secretary shall select a territory of the United States as one of the locations in which to implement the pilot program under this subsection, unless no organization in a territory is able to comply with the requirements under paragraph (1)(B).

"(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 items and services under this title, particularly with regard to the care of complex patients;

''(ii) improvement in reducing health disparities;

''(iii) reductions in preventable hospitalizations;

''(iv) prevention of readmissions;

''(v) reductions in emergency room visits;

''(vi) improvement in health outcomes, including patient functional status where applicable;

''(vii) improvement in patient satisfaction;

''(viii) improved efficiency of care such as reducing duplicative diagnostic tests and laboratory tests; and

''(ix) reductions in health care expenditures; and

''(B) the feasability and advisability of reimbursing medical homes for medical home services under this title on a permanent basis.

''(2) REPORT.—Not later than 60 days after the date of completion of the evaluation under paragraph (1), the Secretary shall submit to Congress and make available to the public a report on the findings of the evaluation under paragraph (1) and the extent to which standards for the certification of medical homes need to be periodically updated.

''(3) EXPANSION OF PROGRAM.—

''(A) IN GENERAL.—Subject to the results of the evaluation under paragraph (1) and subparagraph (B), the Secretary may issue regulations to implement, on a permanent basis, one or more models, if, and to the extent that such model or models, are beneficial to the program under this title, including that such implementation will improve quality of care, as determined by the Secretary.

''(B) CERTIFICATION REQUIREMENT.—The Secretary may not issue such regulations unless the Chief Actuary of the Centers for Medicare & Medicaid Services certifies that the expansion of the components of the pilot program described in subparagraph (A) would result in estimated spending under this title that would be no more than the level of spending that the

Secretary estimates would otherwise be spent under this title in the absence of such expansion.

''(C) UPDATED STANDARDS.—The Secretary shall periodically review and update the standards for qualification as an independent patient centered medical home and as a community based medical home and shall establish a process for ensuring that medical homes meet such updated standards, as applicable

''(f) ADMINISTRATIVE PROVISIONS.—

''(1) NO DUPLICATION IN PAYMENTS FOR INDIVIDUALS IN MEDICAL HOMES.—During any month, the Secretary may not make payments under this section under more than one model or through more than one medical home under any model for the furnishing of medical home services to an individual.

''(2) NO EFFECT ON PAYMENT FOR MEDICAL VISITS.—Payments made under this section are in addition to, and have no effect on the amount of, payment for medical visits made under this title

''(3) ADMINISTRATION.—Chapter 35 of title 44, United States Code shall not apply to this section.

''(4) NO DUPLICATION IN PHYSICIAN PILOT PARTICIPATION.—The Secretary shall not make pay-

ments to an independent or community based medical home both under this section and section 1866E or 1866G, unless the pilot program under this section has been implemented on a permanent basis under subsection (e)(3).

''(5) WAIVER.—The Secretary may waive such provisions of this title and title XI in the manner the Secretary determines necessary in order to implement this section.

''(g) FUNDING.—

''(1) OPERATIONAL COSTS.—For purposes of administering and carrying out the pilot program (including the design, implementation, technical assistance for and evaluation of such program), in addition to funds otherwise available, there shall be transferred from the Federal Supplementary Medical Insurance Trust Fund under section 1841 to the Secretary for the Centers for Medicare & Medicaid Services Program Management Account $6,000,000 for each of fiscal years 2010 through 2014. Amounts appropriated under this paragraph for a fiscal year shall be available until expended.

''(2) PATIENT-CENTERED MEDICAL HOME SERVICES.—In addition to funds otherwise available, there shall be available to the Secretary for the Cen-

ters for Medicare & Medicaid Services, from the Federal Supplementary Medical Insurance Trust Fund under section 1841—

"(A) $200,000,000 for each of fiscal years 2010 through 2014 for payments for medical home services under subsection (c)(3); and

"(B) $125,000,000 for each of fiscal years 2012 through 2016, for payments under subsection (d)(5).

Amounts available under this paragraph for a fiscal year shall be available until expended.

"(3) INITIAL IMPLEMENTATION.—In addition to funds otherwise available, there shall be available to the Secretary for the Centers for Medicare & Medicaid Services, from the Federal Supplementary Medical Insurance Trust Fund under section 1841, $2,500,000 for each of fiscal years 2010 through 2012, under subsection (d)(6). Amounts available under this paragraph for a fiscal year shall be available until expended.

"(h) TREATMENT OF TRHCA MEDICARE MEDICAL HOME DEMONSTRATION FUNDING.—

"(1) In addition to funds otherwise available for payment of medical home services under subsection (c)(3), there shall also be available the amount pro-

vided in subsection (g) of section 204 of division B of the Tax Relief and Health Care Act of 2006 (42 U.S.C. 1395b–1 note), as added by section 133 of the Medicare Improvements for Patients and Providers Act of 2008 (Public Law 110-275).

''(2) Notwithstanding section 1302(c) of the Affordable Health Care for America Act, in addition to funds provided in paragraph (1) and subsection (g)(2)(A), the funding for medical home services that would otherwise have been available if such section 204 medical home demonstration had been implemented (without regard to subsection (g) of such section) shall be available to the independent patient-centered medical home model described in subsection (c).''.

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to services furnished on or after the date of the enactment of this Act.

(c) CONFORMING REPEAL.—Section 204 of division B of the Tax Relief and Health Care Act of 2006 (42 U.S.C. 1395b–1 note), as amended by section 133(a)(2) of the Medicare Improvements for Patients and Providers Act of 2008 (Public Law 110–275), is repealed.

SEC. 1303. PAYMENT INCENTIVE FOR SELECTED PRIMARY CARE SERVICES.

(a) IN GENERAL.—Section 1833 of the Social Security Act is amended by inserting after subsection (o) the following new subsection:

''(p) PRIMARY CARE PAYMENT INCENTIVES.—

''(1) IN GENERAL.—In the case of primary care services (as defined in paragraph (2)) furnished on or after January 1, 2011, by a primary care practitioner (as defined in paragraph (3)) for which amounts are payable under section 1848, in addition to the amount otherwise paid under this part there shall also be paid to the practitioner (or to an employer or facility in the cases described in clause (A) of section 1842(b)(6)) (on a monthly or quarterly basis) from the Federal Supplementary Medical Insurance Trust Fund an amount equal 5 percent (or 10 percent if the practitioner predominately furnishes such services in an area that is designated (under section 332(a)(1)(A) of the Public Health Service Act) as a primary care health professional shortage area.

''(2) PRIMARY CARE SERVICES DEFINED.—In this subsection, the term 'primary care services'—

''(A) mean evaluation and management services, without regard to the specialty of the

physician furnishing the services, that are procedure codes (for services covered under this title) for—

''(i) services in the category designated Evaluation and Management in the Health Care Common Procedure Coding System (established by the Secretary under section 1848(c)(5) as of December 31, 2009, and as subsequently modified by the Secretary); and

''(ii) preventive services (as defined in section 1861(iii) for which payment is made under this section; and

''(B) includes services furnished by another health care professional that would be described in subparagraph (A) if furnished by a physician.

''(3) PRIMARY CARE PRACTITIONER DEFINED.—In this subsection, the term 'primary care practitioner'—

''(A) means a physician or other health care practitioner (including a nurse practitioner) who—

''(i) specializes in family medicine, general internal medicine, general pediat-

rics, geriatrics, or obstetrics and gynecology; and

''(ii) has allowed charges for primary care services that account for at least 50 percent of the physician's or practitioner's total allowed charges under section 1848, as determined by the Secretary for the most recent period for which data are available; and

''(B) includes a physician assistant who is under the supervision of a physician described in subparagraph (A).

''(4) LIMITATION ON REVIEW.—There shall be no administrative or judicial review under section 1869, section 1878, or otherwise, respecting—

''(A) any determination or designation under this subsection;

''(B) the identification of services as primary care services under this subsection; and

''(C) the identification of a practitioner as a primary care practitioner under this subsection.

''(5) COORDINATION WITH OTHER PAYMENTS.—

''(A) WITH OTHER PRIMARY CARE INCENTIVES.—The provisions of this subsection shall not be taken into account in applying subsections (m) and (u) and any payment under such subsections shall not be taken into account in computing payments under this subsection.

''(B) WITH QUALITY INCENTIVES.—Payments under this subsection shall not be taken into account in determining the amounts that would otherwise be paid under this part for purposes of section 1834(g)(2)(B).''.

(b) CONFORMING AMENDMENTS.—

(1) Section 1833(m) of such Act (42 U.S.C. 1395l(m)) is amended by redesignating paragraph (4) as paragraph (5) and by inserting after paragraph (3) the following new paragraph:

''(4) The provisions of this subsection shall not be taken into account in applying subsections (m) or (u) and any payment under such subsections shall not be taken into account in computing payments under this subsection.''.

(2) Section 1848(m)(5)(B) of such Act (42 U.S.C. 1395w–4(m)(5)(B)) is amended by inserting '', (p),'' after ''(m)''.

(3) Section 1848(o)(1)(B)(iv) of such Act (42 U.S.C. 1395w–4(o)(1)(B)(iv)) is amended by inserting ''primary care'' before ''health professional shortage area''.

SEC. 1304. INCREASED REIMBURSEMENT RATE FOR CERTIFIED NURSE-MIDWIVES.

(a) IN GENERAL.—Section 1833(a)(1)(K) of the Social Security Act (42 U.S.C.1395l(a)(1)(K)) is amended by striking ''(but in no event'' and all that follows through ''performed by a physician)''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to services furnished on or after January 1, 2011.

SEC. 1305. COVERAGE AND WAIVER OF COST-SHARING FOR PREVENTIVE SERVICES.

(a) MEDICARE COVERED PREVENTIVE SERVICES DEFINED.—Section 1861 of the Social Security Act (42 U.S.C. 1395x), as amended by section 1233(a)(1)(B), is amended by adding at the end the following new subsection:

''Medicare Covered Preventive Services

''(iii)(1) Subject to the succeeding provisions of this subsection, the term 'Medicare covered preventive services' means the following:

''(A) Prostate cancer screening tests (as defined in subsection (oo)).

''(B) Colorectal cancer screening tests (as defined in subsection (pp).

''(C) Diabetes outpatient self-management training services (as defined in subsection (qq)).

''(D) Screening for glaucoma for certain individuals (as described in subsection (s)(2)(U)).

''(E) Medical nutrition therapy services for certain individuals (as described in subsection (s)(2)(V)).

''(F) An initial preventive physical examination (as defined in subsection (ww)).

''(G) Cardiovascular screening blood tests (as defined in subsection (xx)(1)).

''(H) Diabetes screening tests (as defined in subsection (yy)).

''(I) Ultrasound screening for abdominal aortic aneurysm for certain individuals (as described in subsection (s)(2)(AA)).

''(J) Federally approved and recommended vaccines and their administration as described in subsection (s)(10).

''(K) Screening mammography (as defined in subsection (jj)).

''(L) Screening pap smear and screening pelvic exam (as defined in subsection (nn)).

''(M) Bone mass measurement (as defined in subsection (rr)).

''(N) Kidney disease education services (as defined in subsection (ggg)).

''(O) Additional preventive services (as defined in subsection (ddd)).

''(2) With respect to specific Medicare covered preventive services, the limitations and conditions described in the provisions referenced in paragraph (1) with respect to such services shall apply.''.

(b) PAYMENT AND ELIMINATION OF COST-SHARING.—

(1) IN GENERAL.—

(A) IN GENERAL.—Section 1833(a) of the Social Security Act (42 U.S.C. 1395l(a)) is amended by adding after and below paragraph (9) the following:

''With respect to Medicare covered preventive services, in any case in which the payment rate otherwise provided under this part is computed as a percent of less than 100 percent of an actual charge, fee schedule rate, or other rate, such percentage shall be increased to 100 percent.''.

(B) APPLICATION TO SIGMOIDOSCOPIES AND COLONOSCOPIES.—Section 1834(d) of such Act (42 U.S.C. 1395m(d)) is amended—

(i) in paragraph (2)(C), by amending clause (ii) to read as follows:

''(ii) NO COINSURANCE.—In the case of a beneficiary who receives services described in clause (i), there shall be no coinsurance applied.''; and

(ii) in paragraph (3)(C), by amending clause (ii) to read as follows:

''(ii) NO COINSURANCE.—In the case of a beneficiary who receives services described in clause (i), there shall be no coinsurance applied.''.

(2) ELIMINATION OF COINSURANCE IN OUTPATIENT HOSPITAL SETTINGS.—

(A) EXCLUSION FROM OPD FEE SCHEDULE.—Section 1833(t)(1)(B)(iv) of the Social Security Act (42 U.S.C. 1395l(t)(1)(B)(iv)) is amended by striking ''screening mammography (as defined in section 1861(jj)) and diagnostic mammography'' and inserting ''diagnostic mammograms and Medicare covered preventive services (as defined in section 1861(iii)(1))''.

(B) CONFORMING AMENDMENTS.—Section 1833(a)(2) of the Social Security Act (42 U.S.C. 1395l(a)(2)) is amended—

(i) in subparagraph (F), by striking ''and'' after the semicolon at the end;

(ii) in subparagraph (G), by adding ''and'' at the end; and

(iii) by adding at the end the following new subparagraph:

''(H) with respect to additional preventive services (as defined in section 1861(ddd)) furnished by an outpatient department of a hospital, the amount determined under paragraph (1)(W);''.

(3) WAIVER OF APPLICATION OF DEDUCTIBLE FOR ALL PREVENTIVE SERVICES.—The first sentence of section 1833(b) of the Social Security Act (42 U.S.C. 1395l(b)) is amended—

(A) in clause (1), by striking ''items and services described in section 1861(s)(10)(A)'' and inserting ''Medicare covered preventive services (as defined in section 1861(iii))'';

(B) by inserting ''and'' before ''(4)''; and

(C) by striking clauses (5) through (8).

(4) APPLICATION TO PROVIDERS OF SERVICES.—Section 1866(a)(2)(A)(ii) of such Act (42 U.S.C. 1395cc(a)(2)(A)(ii)) is amended by inserting ''other than for Medicare covered preventive services and'' after ''for such items and services (''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after January 1, 2011.

(d) PREVENTIVE SERVICES.—

(1) REPORT TO CONGRESS ON BARRIERS TO PREVENTIVE SERVICES.—Not later than 12 months after the date of the enactment of this Act, the Secretary of Health and Human Services shall report to Congress on barriers, if any, facing Medicare beneficiaries in accessing the benefit to abdominal aortic aneurysm screening and other preventative services through the Welcome to Medicare Physical Exam.

(2) ABDOMINAL AORTIC ANEURYSM SCREEN ACCESS.—The Secretary shall, to the extent practical, identify and implement policies promoting proper use of abdominal aortic aneurysm screening among Medicare beneficiaries at risk for such aneurysms.

SEC. 1306. WAIVER OF DEDUCTIBLE FOR COLORECTAL CANCER SCREENING TESTS REGARDLESS OF CODING, SUBSEQUENT DIAGNOSIS, OR ANCILLARY TISSUE REMOVAL.

(a) IN GENERAL.—Section 1833 of the Social Security Act (42 U.S.C. 1395l(b)), as amended by section 1305(b), is further amended—

(1) in subsection (a), in the sentence added by section 1305(b)(1)(A), by inserting ''(including services described in the last sentence of section 1833(b))'' after ''preventive services''; and

(2) in subsection (b), by adding at the end the following new sentence: ''Clause (1) of the first sentence of this subsection shall apply with respect to a colorectal cancer screening test regardless of the code that is billed for the establishment of a diagnosis as a result of the test, or for the removal of tissue or other matter or other procedure that is furnished in connection with, as a result of, and in the same clinical encounter as, the screening test.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to items and services furnished on or after January 1, 2011.

SEC. 1307. EXCLUDING CLINICAL SOCIAL WORKER SERVICES FROM COVERAGE UNDER THE MEDICARE SKILLED NURSING FACILITY PROSPECTIVE PAYMENT SYSTEM AND CONSOLIDATED PAYMENT.

(a) IN GENERAL.—Section 1888(e)(2)(A)(ii) of the Social Security Act (42 U.S.C. 1395yy(e)(2)(A)(ii)) is amended by inserting ''clinical social worker services,'' after ''qualified psychologist services,''.

(b) CONFORMING AMENDMENT.—Section 1861(hh)(2) of the Social Security Act (42 U.S.C. 1395x(hh)(2)) is amended by striking ''and other than services furnished to an inpatient of a skilled nursing facility which the facility is required to provide as a requirement for participation''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to items and services furnished on or after October 1, 2010.

SEC. 1308. COVERAGE OF MARRIAGE AND FAMILY THERAPIST SERVICES AND MENTAL HEALTH COUNSELOR SERVICES.

(a) COVERAGE OF MARRIAGE AND FAMILY THERAPIST SERVICES.—

(1) COVERAGE OF SERVICES.—Section 1861(s)(2) of the Social Security Act (42 U.S.C.

1395x(s)(2)), as amended by section 1235, is amended—

(A) in subparagraph (EE), by striking ''and'' at the end;

(B) in subparagraph (FF), by adding ''and'' at the end; and

(C) by adding at the end the following new subparagraph:

''(GG) marriage and family therapist services (as defined in subsection (jjj));''.

(2) DEFINITION.—Section 1861 of the Social Security Act (42 U.S.C. 1395x), as amended by sections 1233 and 1305, is amended by adding at the end the following new subsection:

''Marriage and Family Therapist Services

''(jjj)(1) The term 'marriage and family therapist services' means services performed by a marriage and family therapist (as defined in paragraph (2)) for the diagnosis and treatment of mental illnesses, which the marriage and family therapist is legally authorized to perform under State law (or the State regulatory mechanism provided by State law) of the State in which such services are performed, as would otherwise be covered if furnished by a physician or as incident to a physician's professional service, but only if no facility or other provider charges

or is paid any amounts with respect to the furnishing of such services.

''(2) The term 'marriage and family therapist' means an individual who—

''(A) possesses a master's or doctoral degree which qualifies for licensure or certification as a marriage and family therapist pursuant to State law;

''(B) after obtaining such degree has performed at least 2 years of clinical supervised experience in marriage and family therapy; and

''(C) is licensed or certified as a marriage and family therapist in the State in which marriage and family therapist services are performed.''.

(3) PROVISION FOR PAYMENT UNDER PART B.—Section 1832(a)(2)(B) of the Social Security Act (42 U.S.C. 1395k(a)(2)(B)) is amended by adding at the end the following new clause:

''(v) marriage and family therapist services;''.

(4) AMOUNT OF PAYMENT.—

(A) IN GENERAL.—Section 1833(a)(1) of the Social Security Act (42 U.S.C. 1395l(a)(1)) is amended—

(i) by striking ''and'' before ''(W)''; and

(ii) by inserting before the semicolon at the end the following: '', and (X) with respect to marriage and family therapist services under section 1861(s)(2)(GG), the amounts paid shall be 80 percent of the lesser of the actual charge for the services or 75 percent of the amount determined for payment of a psychologist under clause (L)''.

(B) DEVELOPMENT OF CRITERIA WITH RESPECT TO CONSULTATION WITH A HEALTH CARE PROFESSIONAL.—The Secretary of Health and Human Services shall, taking into consideration concerns for patient confidentiality, develop criteria with respect to payment for marriage and family therapist services for which payment may be made directly to the marriage and family therapist under part B of title XVIII of the Social Security Act (42 U.S.C. 1395j et seq.) under which such a therapist must agree to consult with a patient's attending or primary care physician or nurse practitioner in accordance with such criteria.

(5) EXCLUSION OF MARRIAGE AND FAMILY THERAPIST SERVICES FROM SKILLED NURSING FACILITY PROSPECTIVE PAYMENT SYSTEM.—Section 1888(e)(2)(A)(ii) of the Social Security Act (42 U.S.C. 1395yy(e)(2)(A)(ii)), as amended by section 1307(a), is amended by inserting ''marriage and family therapist services (as defined in subsection (jjj)(1)),'' after ''clinical social worker services,''.

(6) COVERAGE OF MARRIAGE AND FAMILY THERAPIST SERVICES PROVIDED IN RURAL HEALTH CLINICS AND FEDERALLY QUALIFIED HEALTH CENTERS.—Section 1861(aa)(1)(B) of the Social Security Act (42 U.S.C. 1395x(aa)(1)(B)) is amended by striking ''or by a clinical social worker (as defined in subsection (hh)(1)),'' and inserting '', by a clinical social worker (as defined in subsection (hh)(1)), or by a marriage and family therapist (as defined in subsection (jjj)(2)),''.

(7) INCLUSION OF MARRIAGE AND FAMILY THERAPISTS AS PRACTITIONERS FOR ASSIGNMENT OF CLAIMS.—Section 1842(b)(18)(C) of the Social Security Act (42 U.S.C. 1395u(b)(18)(C)) is amended by adding at the end the following new clause:

''(vii) A marriage and family therapist (as defined in section 1861(jjj)(2)).''.

(b) COVERAGE OF MENTAL HEALTH COUNSELOR SERVICES.—

(1) COVERAGE OF SERVICES.—Section 1861(s)(2) of the Social Security Act (42 U.S.C. 1395x(s)(2)), as previously amended, is further amended—

(A) in subparagraph (FF), by striking ''and'' at the end;

(B) in subparagraph (GG), by inserting ''and'' at the end; and

(C) by adding at the end the following new subparagraph:

''(HH) mental health counselor services (as defined in subsection (kkk)(1));''.

(2) DEFINITION.—Section 1861 of the Social Security Act (42 U.S.C. 1395x), as previously amended, is amended by adding at the end the following new subsection:

''Mental Health Counselor Services

''(kkk)(1) The term 'mental health counselor services' means services performed by a mental health counselor (as defined in paragraph (2)) for the diagnosis and treatment of mental illnesses which the mental health counselor is legally authorized to perform under State law (or the State regulatory mechanism provided by the State law) of

the State in which such services are performed, as would otherwise be covered if furnished by a physician or as incident to a physician's professional service, but only if no facility or other provider charges or is paid any amounts with respect to the furnishing of such services.

''(2) The term 'mental health counselor' means an individual who—

''(A) possesses a master's or doctor's degree which qualifies the individual for licensure or certification for the practice of mental health counseling in the State in which the services are performed;

''(B) after obtaining such a degree has performed at least 2 years of supervised mental health counselor practice; and

''(C) is licensed or certified as a mental health counselor or professional counselor by the State in which the services are performed.''.

(3) PROVISION FOR PAYMENT UNDER PART B.—Section 1832(a)(2)(B) of the Social Security Act (42 U.S.C. 1395k(a)(2)(B)), as amended by subsection (a)(3), is further amended—

(A) by striking ''and'' at the end of clause (iv);

(B) by adding ''and'' at the end of clause (v); and

(C) by adding at the end the following new clause:

''(vi) mental health counselor services;''.

(4) AMOUNT OF PAYMENT.—

(A) IN GENERAL.—Section 1833(a)(1) of the Social Security Act (42 U.S.C. 1395l(a)(1)), as amended by subsection (a), is further amended—

(i) by striking ''and'' before ''(X)''; and

(ii) by inserting before the semicolon at the end the following: '', and (Y), with respect to mental health counselor services under section 1861(s)(2)(HH), the amounts paid shall be 80 percent of the lesser of the actual charge for the services or 75 percent of the amount determined for payment of a psychologist under clause (L)''.

(B) DEVELOPMENT OF CRITERIA WITH RESPECT TO CONSULTATION WITH A PHYSICIAN.—The Secretary of Health and Human Services shall, taking into consideration concerns for patient confidentiality, develop criteria with re-

spect to payment for mental health counselor services for which payment may be made directly to the mental health counselor under part B of title XVIII of the Social Security Act (42 U.S.C. 1395j et seq.) under which such a counselor must agree to consult with a patient's attending or primary care physician in accordance with such criteria.

(5) EXCLUSION OF MENTAL HEALTH COUNSELOR SERVICES FROM SKILLED NURSING FACILITY PROSPECTIVE PAYMENT SYSTEM.—Section 1888(e)(2)(A)(ii) of the Social Security Act (42 U.S.C. 1395yy(e)(2)(A)(ii)), as amended by section 1307(a) and subsection (a), is amended by inserting ''mental health counselor services (as defined in section 1861(kkk)(1)),'' after ''marriage and family therapist services (as defined in subsection (jjj)(1)),''.

(6) COVERAGE OF MENTAL HEALTH COUNSELOR SERVICES PROVIDED IN RURAL HEALTH CLINICS AND FEDERALLY QUALIFIED HEALTH CENTERS.—Section 1861(aa)(1)(B) of the Social Security Act (42 U.S.C. 1395x(aa)(1)(B)), as amended by subsection (a), is amended by striking ''or by a marriage and family therapist (as defined in sub-

section (jjj)(2)),'' and inserting ''by a marriage and family therapist (as defined in subsection (jjj)(2)), or a mental health counselor (as defined in subsection (kkk)(2)),''.

(7) INCLUSION OF MENTAL HEALTH COUNSELORS AS PRACTITIONERS FOR ASSIGNMENT OF CLAIMS.—Section 1842(b)(18)(C) of the Social Security Act (42 U.S.C. 1395u(b)(18)(C)), as amended by subsection (a)(7), is amended by adding at the end the following new clause:

''(viii) A mental health counselor (as defined in section 1861(kkk)(2)).''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to items and services furnished on or after January 1, 2011.

SEC. 1309. EXTENSION OF PHYSICIAN FEE SCHEDULE MENTAL HEALTH ADD-ON.

Section 138(a)(1) of the Medicare Improvements for Patients and Providers Act of 2008 (Public Law 110–275) is amended by striking ''December 31, 2009'' and inserting ''December 31, 2011''.

SEC. 1310. EXPANDING ACCESS TO VACCINES.

(a) IN GENERAL.—Paragraph (10) of section 1861(s) of the Social Security Act (42 U.S.C. 1395w(s)) is amended to read as follows:

''(10) federally approved and recommended vaccines (as defined in subsection (lll)) and their respective administration;''.

(b) FEDERALLY APPROVED AND RECOMMENDED VACCINES DEFINED.—Section 1861 of such Act is further amended by adding at the end the following new subsection:

''Federally Approved and Recommended Vaccines

''(lll) The term 'federally approved and recommended vaccine' means a vaccine that—

''(1) is licensed under section 351 of the Public Health Service Act, approved under the Federal Food, Drug, and Cosmetic Act, or authorized for emergency use under section 564 of the Federal, Food, Drug, and Cosmetic Act; and

''(2) is recommended by the Director of the Centers for Disease Control and Prevention.''.

(c) CONFORMING AMENDMENTS.—

(1) Section 1833 of such Act (42 U.S.C. 1395l) is amended, in each of subsections (a)(1)(B), (a)(2)(G), and (a)(3)(A), by striking ''1861(s)(10)(A)'' and inserting ''1861(s)(10)'' each place it appears.

(2) Section 1842(o)(1)(A)(iv) of such Act (42 U.S.C. 1395u(o)(1)(A)(iv)) is amended—

(A) by striking ''subparagraph (A) or (B) of''; and

(B) by inserting before the period the following: ''and before January 1, 2011, and influenza vaccines furnished on or after January 1, 2011''.

(3) Section 1847A(c)(6) of such Act (42 U.S.C. 1395w–3a(c)(6)) is amended—

(A) in subparagraph (D)(i), by inserting '', including a vaccine furnished on or after January 1, 2010''; and

(B) by the following new paragraph:

''(H) IMPLEMENTATION.—Chapter 35 of title 44, United States Code shall not apply to manufacturer provision of information pursuant to section 1927(b)(3)(A)(iii) or subsection (f)(2) for purposes of implementation of this section.''.

(4) Section 1860D–2(e)(1) of such Act (42 U.S.C. 1395w–102(e)(1)) is amended by striking ''such term includes a vaccine'' and all that follows through ''its administration) and''.

(5) Section 1861(ww)(2)(A) of such Act (42 U.S.C. 1395x(ww)(2)(A))) is amended by striking ''Pneumococcal, influenza, and hepatitis B vaccine

and administration'' and inserting ''federally approved or authorized vaccines (as defined in subsection (lll)) and their respective administration''.

(6) Section 1927(b)(3)(A)(iii) of such Act (42 U.S.C. 1396r–8(b)(3)(A)(iii)) is amended, in the matter following subclause (III), by inserting ''(A)(iv) (including influenza vaccines furnished on or after January 1, 2011),'' after ''described in subparagraph''.

(7) Section 1847A(f) of such Act (42 U.S.C. 1395w–3a(f)) is amended—

(A) by striking ''For'' and inserting ''(1) IN GENERAL.—For'';

(B) by indenting paragraph (1), as redesignated in subparagraph (A), 2 ems to the left; and—

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

''(2) TREATMENT OF CERTAIN MANUFACTURERS.—In the case of a manufacturer of a drug or biological described in subparagraphs (A)(iv), (C), (D), (E), or (G) of section 1842(o)(1) that does not have a rebate agreement under section 1927(a), no payment may be made under this part for such drug or biological if such manufacturer does not submit

the information described in section 1927(b)(3)(A)(iii) in the same manner as if the manufacturer had such a rebate agreement in effect. Subparagraphs (C) and (D) of section 1927(b)(3) shall apply to information reported pursuant to the previous sentence in the same manner as such subparagraphs apply with respect to information reported pursuant to such section.''.''.

(d) EFFECTIVE DATES.—The amendments made—

(1) by this section (other than by subsection (c)(6)) shall apply to vaccines administered on or after January 1, 2011; and

(2) by subsection (c)(6) shall apply to calendar quarters beginning on or after January 1, 2010.

SEC. 1311. EXPANSION OF MEDICARE-COVERED PREVENTIVE SERVICES AT FEDERALLY QUALIFIED HEALTH CENTERS.

(a) IN GENERAL.—Section 1861(aa)(3)(A) of the Social Security Act (42 U.S.C. 1395w (aa)(3)(A)) is amended to read as follows:

''(A) services of the type described subparagraphs (A) through (C) of paragraph (1) and services described in section 1861(iii); and''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply not later than January 1, 2011.

SEC. 1312. INDEPENDENCE AT HOME DEMONSTRATION PROGRAM.

Title XVIII of the Social Security Act is amended by inserting after section 1866F, as inserted by section 1302, the following new section:

''INDEPENDENCE AT HOME MEDICAL PRACTICE DEMONSTRATION PROGRAM

''SEC. 1866G. (a) ESTABLISHMENT.—

''(1) IN GENERAL.—The Secretary shall conduct a demonstration program (in this section referred to as the 'demonstration program') to test a payment incentive and service delivery model that utilizes physician and nurse practitioner directed home-based primary care teams designed to reduce expenditures and improve health outcomes in the provision of items and services under this title to applicable beneficiaries (as defined in subsection (d)).

''(2) REQUIREMENT.—The demonstration program shall test whether a model described in paragraph (1), which is accountable for providing comprehensive, coordinated, continuous, and accessible care to high-need populations at home and coordinating health care across all treatment settings, results in—

''(A) reducing preventable hospitalizations;

''(B) preventing hospital readmissions;

''(C) reducing emergency room visits;

''(D) improving health outcomes commensurate with the beneficiaries' stage of chronic illness;

''(E) improving the efficiency of care, such as by reducing duplicative diagnostic and laboratory tests;

''(F) reducing the cost of health care services covered under this title; and

''(G) achieving beneficiary and family caregiver satisfaction.

''(b) INDEPENDENCE AT HOME MEDICAL PRACTICE.—

''(1) INDEPENDENCE AT HOME MEDICAL PRACTICE DEFINED.—In this section:

''(A) IN GENERAL.—The term 'independence at home medical practice' means a legal entity that—

''(i) is comprised of an individual physician or nurse practitioner or group of physicians and nurse practitioners that provides care as part of a team that includes physicians, nurses, physician assist-

ants, pharmacists, and other health and social services staff as appropriate who have experience providing home-based primary care to applicable beneficiaries, make in-home visits, and are available 24 hours per day, 7 days per week to carry out plans of care that are tailored to the individual beneficiary's chronic conditions and designed to achieve the results in subsection (a);

''(ii) is organized at least in part for the purpose of providing physicians' services;

''(iii) has documented experience in providing home-based primary care services to high cost chronically ill beneficiaries, as determined appropriate by the Secretary;

''(iv) includes at least 200 applicable beneficiaries as defined in subsection (d);

''(v) has entered into an agreement with the Secretary;

''(vi) uses electronic health information systems, remote monitoring, and mobile diagnostic technology; and

''(vii) meets such other criteria as the Secretary determines to be appropriate to participate in the demonstration program.

''(B) PHYSICIAN.—The term 'physician' includes, except as the Secretary may otherwise provide, any individual who furnishes services for which payment may be made as physicians' services and has the medical training or experience to fulfill the physician's role described in subparagraph (A)(i).

''(2) PARTICIPATION OF NURSE PRACTITIONERS AND PHYSICIAN ASSISTANTS.—Nothing in this section shall be construed to prevent a nurse practitioner or physician assistant from participating in, or leading, a home-based primary care team as part of an independence at home medical practice if—

''(A) all the requirements of this section are met;

''(B) the nurse practitioner or physician assistant, as the case may be, is acting consistent with State law; and

''(C) the nurse practitioner or physician assistant has the medical training or experience to fulfill the nurse practitioner or physician assistant role described in paragraph (1)(A)(i).

''(3) INCLUSION OF PROVIDERS AND PRACTITIONERS.—Nothing in this subsection shall be construed as preventing an independence at home medical practice from including a provider of services or a participating practitioner described in section 1842(b)(18)(C) that is affiliated with the practice under an arrangement structured so that such provider of services or practitioner participates in the demonstration program and shares in any savings under the demonstration program.

''(4) QUALITY AND PERFORMANCE STANDARDS.—

''(A) IN GENERAL.—An independence at home medical practice participating in the demonstration program shall report on quality measures (in such form, manner, and frequency as specified by the Secretary, which may be for the group, for providers of services and suppliers, or both) and report to the Secretary (in a form, manner, and frequency as specified by the Secretary) such data as the Secretary determines appropriate to monitor and evaluate the demonstration program.

''(B) DEVELOPMENT OF QUALITY PERFORMANCE STANDARDS.—The Secretary shall

develop quality performance standards for independence at home medical practices participating in the demonstration program.

''(c) SHARED SAVINGS PAYMENT METHODOLOGY.—

''(1) ESTABLISHMENT OF TARGET SPENDING LEVEL.—The Secretary shall establish annual target spending levels for items and services covered under parts A and B furnished to applicable beneficiaries by qualifying independence at home medical practices under this section. The Secretary may set an aggregate target spending level for all qualifying practices, or may set different target spending levels for groups of practices or a single practice. Such target spending levels may be determined on a per capita basis and shall take into account normal variation in expenditures for items and services covered under parts A and B furnished to such beneficiaries. The target shall also be adjusted for the size of the practice, number of practices included in the target spending level, characteristics of applicable beneficiaries and such other factors as the Secretary determines appropriate. The Secretary may periodically adjust or rebase the target spending level under this paragraph.

''(2) SHARED SAVINGS AMOUNTS.—

''(A) IN GENERAL.—Subject to subparagraph (B), qualifying independence at home medical practices are eligible to receive an incentive payment under this section if aggregate expenditures for a year for applicable beneficiaries are less than the target spending level for qualifying independence at home medical practices for such year. An incentive payment for such year shall be equal to a portion (as determined by the Secretary) of the amount by which total payments for applicable beneficiaries under parts A and B for such year are estimated to be less than 5 percent less than the target spending level for such year, as determined by the Secretary.

''(B) APPORTIONMENT OF SAVINGS.—The Secretary shall designate how, and to what extent, an incentive payment under this section is to be apportioned among qualifying independence at home medical practices, taking into account the size of the practice, characteristics of the individuals enrolled in each practice, performance on quality performance measures, and such other factors as the Secretary determines appropriate.

''(3) SAVINGS TO THE MEDICARE PROGRAM.—The Secretary shall limit incentive payments to each qualifying independence at home medical practice under this paragraph, with respect to a year, as necessary to ensure that the aggregate expenditures for items and services under parts A and B with respect to applicable beneficiaries for such independence at home medical practice (inclusive of shared savings payments) do not exceed the amount that the Secretary estimates would be expended for such items and services for such beneficiaries during such year (taking into account normal variation in expenditures and other factors the Secretary deems appropriate) if the demonstration program under this section were not implemented, minus 5 percent.

''(d) APPLICABLE BENEFICIARIES.—

''(1) DEFINITION.—In this section, the term 'applicable beneficiary' means, with respect to a qualifying independence at home medical practice, an individual who the practice has determined—

''(A) is entitled to benefits under part A and enrolled for benefits under part B;

''(B) is not enrolled in a Medicare Advantage plan under part C or a PACE program under section 1894;

''(C) has 2 or more chronic illnesses, such as congestive heart failure, diabetes, other dementias designated by the Secretary, chronic obstructive pulmonary disease, ischemic heart disease, stroke, Alzheimer's Disease and neurodegenerative diseases, and other diseases and conditions designated by the Secretary which result in high costs under this title;

''(D) within the past 12 months has had a nonelective hospital admission;

''(E) within the past 12 months has received acute or subacute rehabilitation services;

''(F) has 2 or more functional dependencies requiring the assistance of another person (such as bathing, dressing, toileting, walking, or feeding); and

''(G) meets such other criteria as the Secretary determines appropriate.

''(2) PATIENT ELECTION TO PARTICIPATE.—The Secretary shall determine an appropriate method of ensuring that applicable beneficiaries have agreed to enroll in an independence at home medical practice under the demonstration program. Enrollment in the demonstration program shall be voluntary.

''(3) BENEFICIARY ACCESS TO SERVICES.—Nothing in this section shall be construed as encouraging physicians or nurse practitioners to limit applicable beneficiary access to services covered under this title and applicable beneficiaries shall not be required to relinquish access to any benefit under this title as a condition of receiving services from an independence at home medical practice.

''(e) IMPLEMENTATION.—

''(1) STARTING DATE.—The demonstration program shall begin not later than January 1, 2012. An agreement with an independence at home medical practice under the demonstration program may cover not more than a 3-year period.

''(2) NO PHYSICIAN DUPLICATION IN DEMONSTRATION PARTICIPATION.—The Secretary shall not pay an independence at home medical practice under this section that participates in section 1866D or section 1866E.

''(3) NO BENEFICIARY DUPLICATION IN DEMONSTRATION PARTICIPATION.—The Secretary shall ensure that no applicable beneficiary enrolled in an independence at home medical practice under this section is participating in the programs under section 1866D or section 1866E.

''(4) PREFERENCE.—In approving an independence at home medical practice, the Secretary shall give preference to practices that are—

''(A) located in high-cost areas of the country;

''(B) have experience in furnishing health care services to applicable beneficiaries in the home; and

''(C) use electronic medical records, health information technology, and individualized plans of care.

''(5) NUMBER OF PRACTICES.—

''(A) IN GENERAL.—Subject to subparagraph (B), the Secretary shall enter into agreements with as many independence at home medial practices as practicable and consistent with this subsection to test the potential of the independence at home medical practice model under this section in order to achieve the results described in subsection (a) across practices serving varying numbers of applicable beneficiaries.

''(B) LIMITATION.—In selecting qualified independence at home medial practices to participate under the demonstration program, the Secretary shall limit the number of applicable

beneficiaries that may participate in the demonstration program to 10,000.

''(6) WAIVER.—The Secretary may waive such provisions of this title and title XI as the Secretary determines necessary in order to implement the demonstration program.

''(7) ADMINISTRATION.—Chapter 35 of title 44, United States Code, shall not apply to this section.

''(f) EVALUATION AND MONITORING.—

''(1) IN GENERAL.—The Secretary shall evaluate each independence at home medical practice under the demonstration program to assess whether the practice achieved the results described in subsection (a).

''(2) FOLLOWING APPLICABLE BENEFICIARIES.—The Secretary may monitor data on expenditures and quality of services under this title after an applicable beneficiary discontinues receiving services under this title through a qualifying independence at home medical practice.

''(g) REPORTS TO CONGRESS.—The Secretary shall conduct an independent evaluation of the demonstration program and submit to Congress a final report, including best practices under the demonstration program. Such report shall include an analysis of the demonstration pro-

gram on coordination of care, expenditures under this title, applicable beneficiary access to services, and the quality of health care services provided to applicable beneficiaries.

''(h) FUNDING.—For purposes of administering and carrying out the demonstration program, other than for payments for items and services furnished under this title and shared savings under subsection (c), in addition to funds otherwise appropriated, there shall be transferred to the Secretary for the Center for Medicare & Medicaid Services Program Management Account from the Federal Hospital Insurance Trust Fund under section 1817 and the Federal Supplementary Medical Insurance Trust Fund under section 1841 $5,000,000 for each of fiscal years 2010 through 2015. Amounts transferred under this subsection for a fiscal year shall be available until expended.

''(i) ANTIDISCRIMINATION LIMITATION.—The Secretary shall not enter into an agreement with an entity to provide health care items or services under the demonstration program unless such entity guarantees that for individuals eligible to be enrolled in such program, the entity will not deny, limit, or condition the coverage or provision of benefits to which the individual would have other-

wise been entitled to on the basis of health status if not included in this program.

''(j) TERMINATION.—The Secretary may terminate an agreement with an independence at home medical practice if such practice does not receive incentive payments under subsection (c)(2) or consistently fails to meet quality standards.''.

SEC. 1313. RECOGNITION OF CERTIFIED DIABETES EDUCATORS AS CERTIFIED PROVIDERS FOR PURPOSES OF MEDICARE DIABETES OUTPATIENT SELF-MANAGEMENT TRAINING SERVICES.

(a) IN GENERAL.—Section 1861(qq) of the Social Security Act (42 U.S.C. 1395x(qq)) is amended—

(1) in paragraph (1), by inserting ''or by a certified diabetes educator (as defined in paragraph (3))'' after ''paragraph (2)(B)''; and

(2) by adding at the end the following new paragraphs:

''(3) For purposes of paragraph (1), the term 'certified diabetes educator' means an individual who—

''(A) is licensed or registered by the State in which the services are performed as a health care professional;

''(B) specializes in teaching individuals with diabetes to develop the necessary skills and knowledge to manage the individual's diabetic condition; and

''(C) is certified as a diabetes educator by a recognized certifying body (as defined in paragraph (4)).

''(4)(A) For purposes of paragraph (3)(C), the term 'recognized certifying body' means—

''(i) the National Certification Board for Diabetes Educators, or

''(ii) a certifying body for diabetes educators, which is recognized by the Secretary as authorized to grant certification of diabetes educators for purposes of this subsection pursuant to standards established by the Secretary, if the Secretary determines such Board or body, respectively, meets the requirement of subparagraph (B).

''(B) The National Certification Board for Diabetes Educators or a certifying body for diabetes educators meets the requirement of this subparagraph, with respect to the certification of an individual, if the Board or body, respectively, is incorporated and registered to do business in the United

States and requires as a condition of such certification each of the following:

''(i) The individual has a qualifying credential in a specified health care profession.

''(ii) The individual has professional practice experience in diabetes self-management training that includes a minimum number of hours and years of experience in such training.

''(iii) The individual has successfully completed a national certification examination offered by such entity.

''(iv) The individual periodically renews certification status following initial certification.''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to diabetes outpatient self-management training services furnished on or after the first day of the first calendar year that is at least 6 months after the date of the enactment of this Act.

TITLE IV—QUALITY

Subtitle A—Comparative Effectiveness Research

SEC. 1401. COMPARATIVE EFFECTIVENESS RESEARCH.

(a) IN GENERAL.—Title XI of the Social Security Act is amended by adding at the end the following new part:

''PART D—COMPARATIVE EFFECTIVENESS RESEARCH

''comparative effectiveness research

''SEC. 1181. (a) CENTER FOR COMPARATIVE EFFECTIVENESS RESEARCH ESTABLISHED.—

''(1) IN GENERAL.—The Secretary shall establish within the Agency for Healthcare Research and Quality a Center for Comparative Effectiveness Research (in this section referred to as the 'Center') to conduct, support, and synthesize research (including research conducted or supported under section 1013 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003) with respect to the outcomes, effectiveness, and appropriateness of health care services and procedures in order to identify the manner in which diseases, disorders, and other health conditions can most effectively and appropriately be prevented, diagnosed, treated, and managed clinically.

''(2) DUTIES.—The Center shall—

''(A) conduct, support, and synthesize research relevant to the comparative effectiveness of the full spectrum of health care items, services and systems, including pharmaceuticals, medical devices, medical and surgical procedures, and other medical interventions;

''(B) conduct and support systematic reviews of clinical research, including original research conducted subsequent to the date of the enactment of this section;

''(C) continuously develop rigorous scientific methodologies for conducting comparative effectiveness studies, and use such methodologies appropriately;

''(D) submit to the Comparative Effectiveness Research Commission, the Secretary, and Congress appropriate relevant reports described in subsection (d)(2);

''(E) not later than one year after the date of the enactment of this section, enter into an arrangement under which the Institute of Medicine of the National Academy of Sciences shall conduct an evaluation and report on standards of evidence for highly credible research;

''(F) encourage, as appropriate, the development and use of clinical registries and the development of clinical effectiveness research data networks from electronic health records, post marketing drug and medical device surveillance efforts, and other forms of electronic health data; and

''(G) appoint clinical perspective advisory panels for research priorities under this section, which shall consult with patients and other stakeholders and advise the Center on research questions, methods, and evidence gaps in terms of clinical outcomes for the specific research inquiry to be examined with respect to such priority to ensure that the information produced from such research is clinically relevant to decisions made by clinicians and patients at the point of care.

''(3) POWERS.—

''(A) OBTAINING OFFICIAL DATA.—The Center may secure directly from any department or agency of the United States information necessary to enable it to carry out this section. Upon request of the Center, the head of such department or agency shall furnish that information to the Center on an agreed upon schedule.

''(B) DATA COLLECTION.—In order to carry out its functions, the Center shall—

''(i) utilize existing information, both published and unpublished, where possible, collected and assessed either by its own

staff or under other arrangements made in accordance with this section;

''(ii) carry out, or award grants or contracts for, original research and experimentation, where existing information is inadequate; and

''(iii) adopt procedures allowing any interested party to submit information for the use by the Center in making reports and recommendations.

In carrying out clause (ii), the Center may award grants or contracts (or provide for intergovernmental transfers, as applicable) to private entities and governmental agencies with experience in conducting comparative effectiveness research, such as the National Institutes of Health and other relevant Federal health agencies.

''(C) ACCESS OF GAO TO INFORMATION.—The Comptroller General shall have unrestricted access to all deliberations, records, and nonproprietary data of the Center and Commission under subsection (b), immediately upon request.

''(D) PERIODIC AUDIT.—The Center and Commission under subsection (b) shall be sub-

ject to periodic audit by the Comptroller General.

''(b) COMPARATIVE EFFECTIVENESS RESEARCH COMMISSION.—

''(1) IN GENERAL.—There is established an independent Comparative Effectiveness Research Commission (in this section referred to as the 'Commission') to advise the Center and evaluate the activities carried out by the Center under subsection (a) to ensure such activities result in highly credible research and information resulting from such research.

''(2) DUTIES.—The Commission shall—

''(A)(i) recommend to the Center national priorities for research described in subsection (a) which shall take into account—

''(I) disease incidence, prevalence, and burden in the United States;

''(II) evidence gaps in terms of clinical outcomes;

''(III) variations in practice, delivery, and outcomes by geography, treatment site, provider type, disability, variation in age group (including children, adolescents, adults, and seniors), racial and ethnic

background, gender, genetic and molecular subtypes, and other appropriate populations or subpopulations; and

''(IV) the potential for new evidence concerning certain categories, health care services, or treatments to improve patient health and well-being, and the quality of care; and

''(ii) in making such recommendations consult with a broad array of public and private stakeholders, including patients and health care providers and payers;

''(B) monitor the appropriateness of use of the CERTF described in subsection (g) with respect to the timely production of comparative effectiveness research recommended to be a national priority under subparagraph (A);

''(C) identify highly credible research methods and standards of evidence for such research to be considered by the Center;

''(D) review the methodologies developed by the center under subsection (a)(2)(C);

''(E) support forums to increase stakeholder awareness and permit stakeholder feedback on the efforts of the Center to advance

methods and standards that promote highly credible research;

''(F) make recommendations to the Center for policies that would allow for public access of data produced under this section, in accordance with appropriate privacy and proprietary practices, while ensuring that the information produced through such data is timely and credible;

''(G) make recommendations to the Center for the priority for periodic reviews of previous comparative effectiveness research and studies conducted by the Center under subsection (a);

''(H) at least annually review the processes of the Center and make reports to Congress and the President regarding research conducted, supported, or synthesized by the Center to confirm that the information produced by such research is objective, credible, consistent with standards of evidence developed under this section, and developed through a transparent process that includes consultations with appropriate stakeholders;

''(I) make recommendations to the Center for the broad dissemination, consistent with subsection (e), of the findings of research con-

ducted and supported under this section that enables clinicians, patients, consumers, and payers to make more informed health care decisions that improve quality and value; and

''(J) at least twice each year, hold a public meeting with an opportunity for stakeholder input.

The reports under subparagraph (H) shall not be submitted to the Office of Management and Budget or to any other Federal agency or executive department for any purpose prior to transmittal to Congress and the President. Such reports shall be published on the public internet website of the Commission after the date of such transmittal.

''(3) COMPOSITION OF COMMISSION.—

''(A) IN GENERAL.—The members of the Commission shall consist of—

''(i) the Director of the Agency for Healthcare Research and Quality or their designee;

''(ii) the Chief Medical Officer of the Centers for Medicare & Medicaid Services or their designee;

''(iii) the Director of the National Institutes of Health or their designee; and

''(iv) 16 additional members who shall represent broad constituencies of stakeholders including clinicians, patients, researchers, third-party payers, and consumers of Federal and State beneficiary programs.

Of such members, at least 10 shall be practicing physicians, health care practitioners, consumers, or patients.

''(B) QUALIFICATIONS.—

''(i) DIVERSE REPRESENTATION OF PERSPECTIVES.—The members of the Commission shall represent a broad range of perspectives and shall collectively have experience in the following areas:

''(I) Epidemiology.

''(II) Health services research.

''(III) Bioethics.

''(IV) Decision sciences.

''(V) Health disparities.

''(VI) Health economics.

''(ii) DIVERSE REPRESENTATION OF HEALTH CARE COMMUNITY.—At least one member shall represent each of the following health care communities:

''(I) Patients.

''(II) Health care consumers.

''(III) Practicing Physicians, including surgeons.

''(IV) Other health care practitioners engaged in clinical care.

''(V) Organizations with proven expertise in racial and ethnic minority health research.

''(VI) Employers.

''(VII) Public payers.

''(VIII) Insurance plans.

''(IX) Clinical researchers who conduct research on behalf of pharmaceutical or device manufacturers.

''(C) LIMITATION.—No more than 3 of the Members of the Commission may be representatives of pharmaceutical or device manufacturers and such representatives shall be clinical researchers described under subparagraph (B)(ii)(IX).

''(4) APPOINTMENT.—The Comptroller General shall appoint the members of the Commission.

''(5) CHAIRMAN; VICE CHAIRMAN.—The Comptroller General shall designate a member of the

Commission, at the time of appointment of the member, as Chairman and a member as Vice Chairman for that term of appointment, except that in the case of vacancy of the Chairmanship or Vice Chairmanship, the Comptroller General may designate another member for the remainder of that member's term. The Chairman shall serve as an ex officio member of the National Advisory Council of the Agency for Health Care Research and Quality under section 931(c)(3)(B) of the Public Health Service Act.

''(6) TERMS.—

''(A) IN GENERAL.—Except as provided in subparagraph (B), each member of the Commission shall be appointed for a term of 4 years.

''(B) TERMS OF INITIAL APPOINTEES.—Of the members first appointed—

''(i) 8 shall be appointed for a term of 4 years; and

''(ii) 8 shall be appointed for a term of 3 years.

''(7) COMPENSATION.—While serving on the business of the Commission (including travel time), a member of the Commission shall be entitled to compensation at the per diem equivalent of the rate

provided for level IV of the Executive Schedule under section 5315 of title 5, United States Code; and while so serving away from home and the member's regular place of business, a member may be allowed travel expenses, as authorized by the Director of the Commission.

''(8) DIRECTOR AND STAFF; EXPERTS AND CONSULTANTS.—Subject to such review as the Comptroller General deems necessary to assure the efficient administration of the Commission, the Commission may—

''(A) appoint and set the compensation for an Executive Director (subject to the approval of the Comptroller General) and such other personnel as Federal employees under section 2105 of title 5, United States Code, as may be necessary to carry out its duties (without regard to the provisions of title 5, United States Code, governing appointments in the competitive service);

''(B) seek such assistance and support as may be required in the performance of its duties from appropriate Federal departments and agencies;

''(C) enter into contracts or make other arrangements, as may be necessary for the conduct of the work of the Commission (without regard to section 3709 of the Revised Statutes (41 U.S.C. 5));

''(D) make advance, progress, and other payments which relate to the work of the Commission;

''(E) provide transportation and subsistence for persons serving without compensation; and

''(F) prescribe such rules and regulations as it deems necessary with respect to the internal organization and operation of the Commission.

''(9) OBTAINING OFFICIAL DATA.—The Commission may secure directly from any department or agency of the United States information necessary to enable the Commission to carry out this section. Upon request of the Chairman of the Commission, the head of such department or agency shall furnish the information to the Commission on an agreed upon schedule.

''(10) AVAILABILITY OF REPORTS.—The Commission shall transmit to the Secretary a copy of

each report submitted under this subsection and shall make such reports available to the public.

''(11) COORDINATION.—To enhance effectiveness and coordination, the Secretary is encouraged, to the greatest extent possible, to seek coordination between the Commission and the National Advisory Council of the Agency for Healthcare Research and Quality.

''(12) CONFLICTS OF INTEREST.—

''(A) IN GENERAL.—In appointing the members of the Commission or a clinical perspective advisory panel described in subsection (a)(2)(G), the Comptroller General or the Secretary, respectively, shall take into consideration any financial interest (as defined in subparagraph (D)), consistent with this paragraph, and develop a plan for managing any identified conflicts.

''(B) EVALUATION AND CRITERIA.—When considering an appointment to the Commission or a clinical perspective advisory panel described subsection (a)(2)(G), the Comptroller General or the Secretary, respectively, shall review the expertise of the individual and the financial disclosure report filed by the individual

pursuant to the Ethics in Government Act of 1978 for each individual under consideration for the appointment, so as to reduce the likelihood that an appointed individual will later require a written determination as referred to in section 208(b)(1) of title 18, United States Code, a written certification as referred to in section 208(b)(3) of title 18, United States Code, or a waiver as referred to in subparagraph (D)(iii) for service on the Commission at a meeting of the Commission.

''(C) DISCLOSURES; PROHIBITIONS ON PARTICIPATION; WAIVERS.—

''(i) DISCLOSURE OF FINANCIAL INTEREST.—Prior to a meeting of the Commission or a clinical perspective advisory panel described in subsection (a)(2)(G) regarding a 'particular matter' (as that term is used in section 208 of title 18, United States Code), each member of the Commission or the clinical perspective advisory panel who is a full-time Government employee or special Government employee shall disclose to the Comptroller General or Secretary, respectively, financial interests

in accordance with requiring a waiver under section 208(b) of title 18, United States Code, or other interests as deemed relevant by the Secretary.

''(ii) PROHIBITIONS ON PARTICIPATION.—Except as provided under clause (iii), a member of the Commission or a clinical perspective advisory panel described in subsection (a)(2)(G) may not participate with respect to a particular matter considered in meeting of the Commission or the clinical perspective advisory panel if such member has a financial interest that could be affected by the advice given to the Secretary with respect to such matter, excluding interests exempted in regulations issued by the Director of the Office of Government Ethics as too remote or inconsequential to affect the integrity of the services of the Government officers or employees to which such regulations apply.

''(iii) WAIVER.—If the Comptroller General or Secretary, as applicable, determines it necessary to afford the Commission or a clinical perspective advisory panel

described in subsection (a)(2)(G) essential expertise, the Comptroller General or Secretary, respectively, may grant a waiver of the prohibition in clause (ii) to permit a member described in such subparagraph to—

''(I) participate as a non-voting member with respect to a particular matter considered in a meeting of the Commission or a clinical perspective advisory panel, respectively; or

''(II) participate as a voting member with respect to a particular matter considered in a meeting of the Commission.

''(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.

"(13) APPLICATION OF FACA.—The Federal Advisory Committee Act (other than section 14 of such Act) shall apply to the Commission to the extent that the provisions of such Act do not conflict with the requirements of this subsection.

"(c) RESEARCH REQUIREMENTS.—Any research conducted, supported, or synthesized under this section shall meet the following requirements:

"(1) ENSURING TRANSPARENCY, CREDIBILITY, AND ACCESS.—

"(A) The establishment of a research agenda by the Center shall be informed by the na-

tional priorities for research recommended under subsection (b)(2)(A).

''(B) The establishment of the agenda and conduct of the research shall be insulated from inappropriate political or stakeholder influence.

''(C) Methods of conducting such research shall be scientifically based.

''(D) Consistent with applicable law, all aspects of the prioritization of research, conduct of the research, and development of conclusions based on the research shall be transparent to all stakeholders.

''(E) Consistent with applicable law, the process and methods for conducting such research shall be publicly documented and available to all stakeholders.

''(F) Throughout the process of such research, the Center shall provide opportunities for all stakeholders involved to review and provide public comment on the methods and findings of such research.

''(G) Such research shall consider advice given to the Center by the clinical perspective advisory panel for the particular national research priority.

''(2) STAKEHOLDER INPUT.—

''(A) IN GENERAL.—The Commission shall consult with patients, health care providers, health care consumer representatives, and other appropriate stakeholders with an interest in the research through a transparent process recommended by the Commission.

''(B) SPECIFIC AREAS OF CONSULTATION.—Consultation shall include where deemed appropriate by the Commission—

''(i) recommending research priorities and questions;

''(ii) recommending research methodologies; and

''(iii) advising on and assisting with efforts to disseminate research findings.

''(C) OMBUDSMAN.—The Secretary shall designate a patient ombudsman. The ombudsman shall—

''(i) serve as an available point of contact for any patients with an interest in proposed comparative effectiveness studies by the Center; and

''(ii) ensure that any comments from patients regarding proposed comparative

effectiveness studies are reviewed by the Center.

''(3) TAKING INTO ACCOUNT POTENTIAL DIFFERENCES.—Research shall—

''(A) be designed, as appropriate, to take into account the potential for differences in the effectiveness of health care items, services, and systems used with various subpopulations such as racial and ethnic minorities, women, different age groups (including children, adolescents, adults, and seniors), individuals with disabilities, and individuals with different comorbidities and genetic and molecular subtypes; and—

''(B) seek, as feasible and appropriate, to include members of such subpopulations as subjects in the research.

''(d) PUBLIC ACCESS TO COMPARATIVE EFFECTIVENESS INFORMATION.—

''(1) IN GENERAL.—Not later than 90 days after receipt by the Center or Commission, as applicable, of a relevant report described in paragraph (2) made by the Center, Commission, or clinical perspective advisory panel under this section, appropriate information contained in such report shall be

posted on the official public Internet site of the Center and of the Commission, as applicable.

''(2) RELEVANT REPORTS DESCRIBED.—For purposes of this section, a relevant report is each of the following submitted by the Center or a grantee or contractor of the Center:

''(A) Any interim or progress reports as deemed appropriate by the Secretary.

''(B) Stakeholder comments.

''(C) A final report.

''(e) DISSEMINATION AND INCORPORATION OF COMPARATIVE EFFECTIVENESS INFORMATION.—

''(1) DISSEMINATION.—The Center shall provide for the dissemination of appropriate findings produced by research supported, conducted, or synthesized under this section to health care providers, patients, vendors of health information technology focused on clinical decision support, relevant expert organizations (as defined in subsection (i)(3)(A)), and Federal and private health plans, and other relevant stakeholders. In disseminating such findings the Center shall—

''(A) convey findings of research so that they are comprehensible and useful to patients and providers in making health care decisions;

''(B) discuss findings and other considerations specific to certain sub-populations, risk factors, and comorbidities as appropriate;

''(C) include considerations such as limitations of research and what further research may be needed, as appropriate;

''(D) not include any data that the dissemination of which would violate the privacy of research participants or violate any confidentiality agreements made with respect to the use of data under this section; and

''(E) assist the users of health information technology focused on clinical decision support to promote the timely incorporation of such findings into clinical practices and promote the ease of use of such incorporation.

''(2) DISSEMINATION PROTOCOLS AND STRATEGIES.—The Center shall develop protocols and strategies for the appropriate dissemination of research findings in order to ensure effective communication of findings and the use and incorporation of such findings into relevant activities for the purpose of informing higher quality and more effective and efficient decisions regarding medical items and services. In developing and adopting such protocols and strat-

egies, the Center shall consult with stakeholders concerning the types of dissemination that will be most useful to the end users of information and may provide for the utilization of multiple formats for conveying findings to different audiences, including dissemination to individuals with limited English proficiency.

''(f) REPORTS TO CONGRESS.—

''(1) ANNUAL REPORTS.—Beginning not later than one year after the date of the enactment of this section, the Director of the Agency of Healthcare Research and Quality shall submit to Congress an annual report on the activities of the Center, as well as the research, conducted under this section. Each such report shall include a discussion of the Center's compliance with subsection (c)(3)(B), including any reasons for lack of compliance with such subsection.

''(2) RECOMMENDATION FOR FAIR SHARE PER CAPITA AMOUNT FOR ALL-PAYER FINANCING.—Beginning not later than December 31, 2011, the Secretary shall submit to Congress an annual recommendation for a fair share per capita amount described in subsection (c)(1) of section 9511 of the Internal Revenue Code of 1986 for purposes of funding the CERTF under such section.

''(3) ANALYSIS AND REVIEW.—Not later than December 31, 2013, the Secretary, in consultation with the Commission, shall submit to Congress a report on all activities conducted or supported under this section as of such date. Such report shall include an evaluation of the overall costs of such activities and an analysis of the backlog of any research proposals approved by the Center but not funded.

''(g) FUNDING OF COMPARATIVE EFFECTIVENESS RESEARCH.—For fiscal year 2010 and each subsequent fiscal year, amounts in the Comparative Effectiveness Research Trust Fund (referred to in this section as the 'CERTF') under section 9511 of the Internal Revenue Code of 1986 shall be available in accordance with such section, without the need for further appropriations and without fiscal year limitation, to carry out this section.

''(h) CONSTRUCTION.—

''(1) COVERAGE.—Nothing in this section shall be construed—

''(A) to permit the Center or Commission to mandate coverage, reimbursement, or other policies for any public or private payer; or

''(B) as preventing the Secretary from covering the routine costs of clinical care received

by an individual entitled to, or enrolled for, benefits under title XVIII, XIX, or XXI in the case where such individual is participating in a clinical trial and such costs would otherwise be covered under such title with respect to the beneficiary.

''(2) REPORTS AND FINDINGS.—None of the reports submitted under this section or research findings disseminated by the Center or Commission shall be construed as mandates, for payment, coverage, or treatment.

''(3) PROTECTING THE PHYSICIAN-PATIENT RELATIONSHIP.—Nothing in this section shall be construed to authorize any Federal officer or employee to exercise any supervision or control over the practice of medicine.

''(i) CONSULTATION WITH RELEVANT EXPERT ORGANIZATIONS.—

''(1) CONSULTATION PRIOR TO INITIATION OF RESEARCH.—Prior to recommending priorities or initiating research described in this section, the Commission or the Center shall consult with the relevant expert organizations responsible for standards and protocols of clinical excellence. Such consulta-

tion shall be consistent with the processes established under subsection (c)(2).

''(2) CONSULTATION IN DISSEMINATION OF RESEARCH.—Any dissemination of research from the Commission or the Center and findings made by the Commission or the Center shall be consistent with processes established under subsection (e) and shall—

''(A) be based upon evidence-based medicine; and

''(B) take into consideration standards and protocols of clinical excellence developed by relevant expert organizations.

''(3) DEFINITIONS.—For purposes of this subsection:

''(A) RELEVANT EXPERT ORGANIZATIONS.—The term 'relevant expert organization' means an organization with expertise in the rigorous application of evidence-based scientific methods for the design of clinical studies, the interpretation of clinical data, and the development of national clinical practice guidelines, including a voluntary health organization, clinical specialty, or other professional organization that represents physicians based on the field of

medicine in which each such physician practices or is board certified.

''(B) STANDARDS AND PROTOCOLS OF CLINICAL EXCELLENCE.—The term 'standards and protocols of clinical excellence' means clinical or practice guidelines that consist of a set of directions or principles that is based on evidence and is designed to assist a health care practitioner with decisions about appropriate diagnostic, therapeutic, or other clinical procedures for specific clinical circumstances.

''(j) RESEARCH MAY NOT BE USED TO DENY OR RATION CARE.—Nothing in this section shall be construed to make more stringent or otherwise change the standards or requirements for coverage of items and services under this Act.''.

(b) COMPARATIVE EFFECTIVENESS RESEARCH TRUST FUND; FINANCING FOR THE TRUST FUND.—For the provision establishing a Comparative Effectiveness Research Trust Fund and financing such Trust Fund, see section 1802.

Subtitle B—Nursing Home Transparency

PART 1—IMPROVING TRANSPARENCY OF INFORMATION ON SKILLED NURSING FACILITIES, NURSING FACILITIES, AND OTHER LONG-TERM CARE 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 (6)(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 Affordable Health Care for America Act, for submission to the Secretary, the Inspector General of the Department of Health and Human Services, the State in which the facility

is located, and the State long-term care ombudsman in the case where the Secretary, the Inspector General, the State, or the State long-term care ombudsman requests such information; and

''(B) beginning on the effective date of the final regulations promulgated under paragraph (4)(A), for reporting such information in accordance with such final regulations.

Nothing in subparagraph (A) shall be construed as authorizing a facility to dispose of or delete information described in such subparagraph after the effective date of the final regulations promulgated under paragraph (4)(A).

''(2) PUBLIC AVAILABILITY OF INFORMATION.—During the period described in paragraph (1)(A), a facility shall—

''(A) make the information described in paragraph (3) available to the public upon request and update such information as may be necessary to reflect changes in such information; and

''(B) post a notice of the availability of such information in the lobby of the facility in a prominent manner.

''(3) INFORMATION DESCRIBED.—

''(A) IN GENERAL.—The following information is described in this paragraph:

''(i) The information described in subsections (a) and (b), subject to subparagraph (C).

''(ii) The identity of and information on—

''(I) each member of the governing body of the facility, including the name, title, and period of service of each such member;

''(II) each person or entity who is an officer, director, member, partner, trustee, or managing employee of the facility, including the name, title, and date of start of service of each such person or entity; and

''(III) each person or entity who is an additional disclosable party of the facility.

''(iii) A description of the organizational structure and the relationship of each person and entity described in sub-

clauses (II) and (III) of clause (ii) to the facility and to one another.

''(B) SPECIAL RULE WHERE INFORMATION IS ALREADY REPORTED OR SUBMITTED.—To the extent that information reported by a facility to the Internal Revenue Service on Form 990, information submitted by a facility to the Securities and Exchange Commission, or information otherwise submitted to the Secretary or any other Federal agency contains the information described in clauses (i), (ii), or (iii) of subparagraph (A), the Secretary may allow, to the extent practicable, such Form or such information to meet the requirements of paragraph (1) and to be submitted in a manner specified by the Secretary.

''(C) SPECIAL RULE.—In applying subparagraph (A)(i)—

''(i) with respect to subsections (a) and (b), 'ownership or control interest' shall include direct or indirect interests, including such interests in intermediate entities; and

''(ii) subsection (a)(3)(A)(ii) shall include the owner of a whole or part interest

in any mortgage, deed of trust, note, or other obligation secured, in whole or in part, by the entity or any of the property or assets thereof, if the interest is equal to or exceeds 5 percent of the total property or assets of the entirety.

''(4) REPORTING.—

''(A) IN GENERAL.—Not later than the date that is 2 years after the date of the enactment of this subsection, the Secretary shall promulgate regulations requiring a facility to report the information described in paragraph (3) to the Secretary in a standardized format, and such other regulations as are necessary to carry out this subsection. Such regulations shall specify the frequency of reporting, as determined by the Secretary. Such final regulations shall also require—

''(i) the reporting of such information on or after the first day of the first calendar quarter beginning after the date that is 90 days after the date on which such final regulations are published in the Federal Register; and—

''(ii) the certification, as a condition of participation under the program under title XVIII or XIX, that such information is accurate and current.

''(B) GUIDANCE.—The Secretary shall provide guidance and technical assistance to States on how to adopt the standardized format under subparagraph (A).

''(5) NO EFFECT ON EXISTING REPORTING REQUIREMENTS.—Nothing in this subsection shall reduce, diminish, or alter any reporting requirement for a facility that is in effect as of the date of the enactment of this subsection.

''(6) DEFINITIONS.—In this subsection:

''(A) ADDITIONAL DISCLOSABLE PARTY.—The term 'additional disclosable party' means, with respect to a facility, any person or entity who, through ownership interest, partnership interest, contract, or otherwise—

''(i) directly or indirectly exercises operational, financial, administrative, or managerial control or direction over the facility or a part thereof, or provides policies or procedures for any of the operations of

the facility, or provides financial or cash management services to the facility;

''(ii) leases or subleases real property to the facility, or owns a whole or part interest equal to or exceeding 5 percent of the total value of such real property;

''(iii) lends funds or provides a financial guarantee to the facility in an amount which is equal to or exceeds $50,000; or

''(iv) provides management or administrative services, clinical consulting services, or accounting or financial services to the facility.

''(B) FACILITY.—The term 'facility' means a disclosing entity which is—

''(i) a skilled nursing facility (as defined in section 1819(a)); or

''(ii) a nursing facility (as defined in section 1919(a)).

''(C) MANAGING EMPLOYEE.—The term 'managing employee' means, with respect to a facility, an individual (including a general manager, business manager, administrator, director, or consultant) who directly or indirectly man-

ages, advises, or supervises any element of the practices, finances, or operations of the facility.

''(D) ORGANIZATIONAL STRUCTURE.—The term 'organizational structure' means, in the case of—

''(i) a corporation, the officers, directors, and shareholders of the corporation who have an ownership interest in the corporation which is equal to or exceeds 5 percent;

''(ii) a limited liability company, the members and managers of the limited liability company (including, as applicable, what percentage each member and manager has of the ownership interest in the limited liability company);

''(iii) a general partnership, the partners of the general partnership;

''(iv) a limited partnership, the general partners and any limited partners of the limited partnership who have an ownership interest in the limited partnership which is equal to or exceeds 10 percent;

''(v) a trust, the trustees of the trust;

"(vi) an individual, contact information for the individual; and

"(vii) any other person or entity, such information as the Secretary determines appropriate.".

(b) PUBLIC AVAILABILITY OF INFORMATION.—Not later than the date that is 1 year after the date on which the final regulations promulgated under section 1124(c)(4)(A) of the Social Security Act, as added by subsection (a), are published in the Federal Register, the information reported in accordance with such final regulations shall be made available to the public in accordance with procedures established by the Secretary of Health and Human Services.

(a) CONFORMING AMENDMENTS.—

(1) SKILLED NURSING FACILITIES.—Section 1819(d)(1) of the Social Security Act (42 U.S.C. 1395i–3(d)(1)) is amended by striking subparagraph (B) and redesignating subparagraph (C) as subparagraph (B).

(2) NURSING FACILITIES.—Section 1919(d)(1) of the Social Security Act (42 U.S.C. 1396r(d)(1)) is amended by striking subparagraph (B) and redesignating subparagraph (C) as subparagraph (B).

SEC. 1412. ACCOUNTABILITY REQUIREMENTS.

(a) EFFECTIVE COMPLIANCE AND ETHICS PROGRAMS.—

(1) SKILLED NURSING FACILITIES.—Section 1819(d)(1) of the Social Security Act (42 U.S.C. 1395i–3(d)(1)), as amended by section 1411(c)(1), is amended by adding at the end the following new subparagraph:

"(C) COMPLIANCE AND ETHICS PROGRAMS.—

"(i) REQUIREMENT.—On or after the first day of the first calendar quarter beginning after the date that is 1 year after the date on which regulations developed under clause (ii) are published in the Federal Register, a skilled nursing facility shall, with respect to the entity that operates or controls the facility (in this subparagraph referred to as the 'operating organization' or 'organization'), have in operation a compliance and ethics program that is effective in preventing and detecting criminal, civil, and administrative violations under this Act and in promoting quality of care consistent with such regulations.

"(ii) DEVELOPMENT OF REGULATIONS.—

"(I) IN GENERAL.—Not later than the date that is 2 years after the date of the enactment of this subparagraph, the Secretary, in consultation with the Inspector General of the Department of Health and Human Services, shall promulgate regulations for an effective compliance and ethics program for operating organizations, which may include a model compliance program.

"(II) DESIGN OF REGULATIONS.—Such regulations with respect to specific elements or formality of a program may vary with the size of the organization, such that larger organizations should have a more formal and rigorous program and include established written policies defining the standards and procedures to be followed by its employees. Such requirements shall specifically apply to the

corporate level management of multi-unit nursing home chains.

''(III) EVALUATION.—Not later than 3 years after the date on which compliance and ethics programs established under this subparagraph are in operation pursuant to clause (i), the Secretary shall complete an evaluation of such programs. Such evaluation shall determine if such programs led to changes in deficiency citations, changes in quality performance, or changes in other metrics of resident quality of care. The Secretary shall submit to Congress a report on such evaluation and shall include in such report such recommendations regarding changes in the requirements for such programs as the Secretary determines appropriate.

''(iii) REQUIREMENTS FOR COMPLIANCE AND ETHICS PROGRAMS.—In this subparagraph, the term 'compliance and ethics program' means, with respect to a

skilled nursing facility, a program of the operating organization that—

''(I) has been reasonably designed, implemented, and enforced so that it generally will be effective in preventing and detecting criminal, civil, and administrative violations under this Act and in promoting quality of care; and

''(II) includes at least the required components specified in clause (iv).

''(iv) REQUIRED COMPONENTS OF PROGRAM.—The required components of a compliance and ethics program of an organization are the following:

''(I) The organization must have established compliance standards and procedures to be followed by its employees, contractors, and other agents that are reasonably capable of reducing the prospect of criminal, civil, and administrative violations under this Act.

''(II) Specific individuals within high-level personnel of the organization must have been assigned overall responsibility to oversee compliance with such standards and procedures and have sufficient resources and authority to assure such compliance.

''(III) The organization must have used due care not to delegate substantial discretionary authority to individuals whom the organization knew, or should have known through the exercise of due diligence, had a propensity to engage in criminal, civil, and administrative violations under this Act.

''(IV) The organization must have taken steps to communicate effectively its standards and procedures to all employees and other agents, such as by requiring participation in training programs or by disseminating publications that explain in a practical manner what is required.

''(V) The organization must have taken reasonable steps to achieve compliance with its standards, such as by utilizing monitoring and auditing systems reasonably designed to detect criminal, civil, and administrative violations under this Act by its employees and other agents and by having in place and publicizing a reporting system whereby employees and other agents could report violations by others within the organization without fear of retribution.

''(VI) The standards must have been consistently enforced through appropriate disciplinary mechanisms, including, as appropriate, discipline of individuals responsible for the failure to detect an offense.

''(VII) After an offense has been detected, the organization must have taken all reasonable steps to respond appropriately to the offense and to prevent further similar offenses, including repayment of any funds to

which it was not entitled and any necessary modification to its program to prevent and detect criminal, civil, and administrative violations under this Act.

''(VIII) The organization must periodically undertake reassessment of its compliance program to identify changes necessary to reflect changes within the organization and its facilities.

''(v) COORDINATION.—The provisions of this subparagraph shall apply with respect to a skilled nursing facility in lieu of section 1874(d).''.

(2) NURSING FACILITIES.—Section 1919(d)(1) of the Social Security Act (42 U.S.C. 1396r(d)(1)), as amended by section 1411(c)(2), is amended by adding at the end the following new subparagraph:

''(C) COMPLIANCE AND ETHICS PROGRAM.—

''(i) REQUIREMENT.—On or after the first day of the first calendar quarter beginning after the date that is 1 year after the date on which regulations developed

under clause (ii) are published in the Federal Register, a skilled nursing facility shall, with respect to the entity that operates or controls the facility (in this subparagraph referred to as the 'operating organization' or 'organization'), have in operation a compliance and ethics program that is effective in preventing and detecting criminal, civil, and administrative violations under this Act and in promoting quality of care consistent with such regulations.

''(iii) DEVELOPMENT OF REGULATIONS.—

''(I) IN GENERAL.—Not later than the date that is 2 years after the date of the enactment of this subparagraph, the Secretary, in consultation with the Inspector General of the Department of Health and Human Services, shall promulgate regulations for an effective compliance and ethics program for operating organizations, which may include a model compliance program.

''(II) DESIGN OF REGULATIONS.—Such regulations with respect to specific elements or formality of a program may vary with the size of the organization, such that larger organizations should have a more formal and rigorous program and include established written policies defining the standards and procedures to be followed by its employees. Such requirements shall specifically apply to the corporate level management of multi-unit nursing home chains.

''(III) EVALUATION.—Not later than 3 years after the date on which compliance and ethics programs established under this subparagraph are in operation pursuant to clause (i), the Secretary shall complete an evaluation of such programs. Such evaluation shall determine if such programs led to changes in deficiency citations, changes in quality performance, or changes in other metrics of resident quality of care. The Secretary shall

submit to Congress a report on such evaluation and shall include in such report such recommendations regarding changes in the requirements for such programs as the Secretary determines appropriate.

''(v) REQUIREMENTS FOR COMPLIANCE AND ETHICS PROGRAMS.—In this subparagraph, the term 'compliance and ethics program' means, with respect to a nursing facility, a program of the operating organization that—

''(I) has been reasonably designed, implemented, and enforced so that it generally will be effective in preventing and detecting criminal, civil, and administrative violations under this Act and in promoting quality of care; and

''(II) includes at least the required components specified in clause (iv).

''(vi) REQUIRED COMPONENTS OF PROGRAM.—The required components of a

compliance and ethics program of an organization are the following:

''(I) The organization must have established compliance standards and procedures to be followed by its employees and other agents that are reasonably capable of reducing the prospect of criminal, civil, and administrative violations under this Act.

''(II) Specific individuals within high-level personnel of the organization must have been assigned overall responsibility to oversee compliance with such standards and procedures and has sufficient resources and authority to assure such compliance.

''(III) The organization must have used due care not to delegate substantial discretionary authority to individuals whom the organization knew, or should have known through the exercise of due diligence, had a propensity to engage in criminal, civil, and administrative violations under this Act.

''(IV) The organization must have taken steps to communicate effectively its standards and procedures to all employees and other agents, such as by requiring participation in training programs or by disseminating publications that explain in a practical manner what is required.

''(V) The organization must have taken reasonable steps to achieve compliance with its standards, such as by utilizing monitoring and auditing systems reasonably designed to detect criminal, civil, and administrative violations under this Act by its employees and other agents and by having in place and publicizing a reporting system whereby employees and other agents could report violations by others within the organization without fear of retribution.

''(VI) The standards must have been consistently enforced through appropriate disciplinary mechanisms, including, as appropriate, discipline of

individuals responsible for the failure to detect an offense.

''(VII) After an offense has been detected, the organization must have taken all reasonable steps to respond appropriately to the offense and to prevent further similar offenses, including repayment of any funds to which it was not entitled and any necessary modification to its program to prevent and detect criminal, civil, and administrative violations under this Act.

''(VIII) The organization must periodically undertake reassessment of its compliance program to identify changes necessary to reflect changes within the organization and its facilities.

''(vii) COORDINATION.—The provisions of this subparagraph shall apply with respect to a nursing facility in lieu of section 1902(a)(77).''.

(b) QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT PROGRAM.—

(1) SKILLED NURSING FACILITIES.—Section 1819(b)(1)(B) of the Social Security Act (42 U.S.C. 1396r(b)(1)(B)) is amended—

(A) by striking ''ASSURANCE'' and inserting ''ASSURANCE AND QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT PROGRAM'';

(B) by designating the matter beginning with ''A skilled nursing facility'' as a clause (i) with the heading ''IN GENERAL.—'' and the appropriate indentation;

(C) in clause (i) (as so designated by subparagraph (B)), by redesignating clauses (i) and (ii) as subclauses (I) and (II), respectively; and

(D) by adding at the end the following new clause:

''(ii) QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT PROGRAM.—

''(I) IN GENERAL.—Not later than December 31, 2011, the Secretary shall establish and implement a quality assurance and performance improvement program (in this clause referred to as the 'QAPI program') for skilled nursing facilities, including

multi-unit chains of such facilities. Under the QAPI program, the Secretary shall establish standards relating to such facilities and provide technical assistance to such facilities on the development of best practices in order to meet such standards. Not later than 1 year after the date on which the regulations are promulgated under subclause (II), a skilled nursing facility must submit to the Secretary a plan for the facility to meet such standards and implement such best practices, including how to coordinate the implementation of such plan with quality assessment and assurance activities conducted under clause (i).

''(II) REGULATIONS.—The Secretary shall promulgate regulations to carry out this clause.''.

(2) NURSING FACILITIES.—Section 1919(b)(1)(B) of the Social Security Act (42 U.S.C. 1396r(b)(1)(B)) is amended—

(A) by striking ''ASSURANCE'' and inserting ''ASSURANCE AND QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT PROGRAM'';

(B) by designating the matter beginning with ''A nursing facility'' as a clause (i) with the heading ''IN GENERAL.—'' and the appropriate indentation; and

(C) by adding at the end the following new clause:

''(ii) QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT PROGRAM.—

''(I) IN GENERAL.—Not later than December 31, 2011, the Secretary shall establish and implement a quality assurance and performance improvement program (in this clause referred to as the 'QAPI program') for nursing facilities, including multi-unit chains of such facilities. Under the QAPI program, the Secretary shall establish standards relating to such facilities and provide technical assistance to such facilities on the development of best practices in order to meet such standards. Not later than 1

year after the date on which the regulations are promulgated under subclause (II), a nursing facility must submit to the Secretary a plan for the facility to meet such standards and implement such best practices, including how to coordinate the implementation of such plan with quality assessment and assurance activities conducted under clause (i).

''(II) REGULATIONS.—The Secretary shall promulgate regulations to carry out this clause.''.

(3) PROPOSAL TO REVISE QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT PROGRAMS.—The Secretary shall implement policies that modify and strengthen quality assurance and performance improvement programs in skilled nursing facilities and nursing facilities on a periodic basis, as determined by the Secretary.

(4) FACILITY PLAN.—Not later than 1 year after the date on which the regulations are promulgated under subclause (II) of clause (ii) of sections 1819(b)(1)(B) and 1919(b)(1)(B) of the Social Security Act, as added by paragraphs (1) and (2), a

skilled nursing facility and a nursing facility must submit to the Secretary a plan for the facility to meet the standards under such regulations and implement such best practices, including how to coordinate the implementation of such plan with quality assessment and assurance activities conducted under clause (i) of such sections.

(c) GAO STUDY ON NURSING FACILITY UNDERCAPITALIZATION.—

(1) IN GENERAL.—The Comptroller General of the United States shall conduct a study that examines the following:

(A) The extent to which corporations that own or operate large numbers of nursing facilities, taking into account ownership type (including private equity and control interests), are undercapitalizing such facilities.

(B) The effects of such undercapitalization on quality of care, including staffing and food costs, at such facilities.

(C) Options to address such undercapitalization, such as requirements relating to surety bonds, liability insurance, or minimum capitalization.

(2) REPORT.—Not later than 18 months after the date of the enactment of this Act, the Comptroller General shall submit to Congress a report on the study conducted under paragraph (1).

(3) NURSING FACILITY.—In this subsection, the term ''nursing facility'' includes a skilled nursing facility.

SEC. 1413. NURSING HOME COMPARE MEDICARE WEBSITE.

(a) SKILLED NURSING FACILITIES.—

(1) IN GENERAL.—Section 1819 of the Social Security Act (42 U.S.C. 1395i–3) is amended—

(A) by redesignating subsection (i) as subsection (j); and

(B) by inserting after subsection (h) the following new subsection:

''(i) NURSING HOME COMPARE WEBSITE.—

''(1) INCLUSION OF ADDITIONAL INFORMATION.—

''(A) IN GENERAL.—The Secretary shall ensure that the Department of Health and Human Services includes, as part of the information provided for comparison of nursing homes on the official Internet website of the Federal Government for Medicare beneficiaries (commonly referred to as the 'Nursing Home

Compare' Medicare website) (or a successor website), the following information in a manner that is prominent, easily accessible, readily understandable to consumers of long-term care services, and searchable:

''(i) Information that is reported to the Secretary under section 1124(c)(4).

''(ii) Information on the 'Special Focus Facility program' (or a successor program) established by the Centers for Medicare and Medicaid Services, according to procedures established by the Secretary. Such procedures shall provide for the inclusion of information with respect to, and the names and locations of, those facilities that, since the previous quarter—

''(I) were newly enrolled in the program;

''(II) are enrolled in the program and have failed to significantly improve;

''(III) are enrolled in the program and have significantly improved;

''(IV) have graduated from the program; and

''(V) have closed voluntarily or no longer participate under this title.

''(iii) Staffing data for each facility (including resident census data and data on the hours of care provided per resident per day) based on data submitted under subsection (b)(8)(C), including information on staffing turnover and tenure, in a format that is clearly understandable to consumers of long-term care services and allows such consumers to compare differences in staffing between facilities and State and national averages for the facilities. Such format shall include—

''(I) concise explanations of how to interpret the data (such as a plain English explanation of data reflecting 'nursing home staff hours per resident day');

''(II) differences in types of staff (such as training associated with different categories of staff);

''(III) the relationship between nurse staffing levels and quality of care; and

''(IV) an explanation that appropriate staffing levels vary based on patient case mix.

''(iv) Links to State internet websites with information regarding State survey and certification programs, links to Form 2567 State inspection reports (or a successor form) on such websites, information to guide consumers in how to interpret and understand such reports, and the facility plan of correction or other response to such report.

''(v) The standardized complaint form developed under subsection (f)(8), including explanatory material on what complaint forms are, how they are used, and how to file a complaint with the State survey and certification program and the State long-term care ombudsman program.

''(vi) Summary information on the number, type, severity, and outcome of substantiated complaints.

''(vii) The number of adjudicated instances of criminal violations by employees of a nursing facility—

''(I) that were committed inside the facility;

''(II) with respect to such instances of violations or crimes committed inside of the facility that were the violations or crimes of abuse, neglect, and exploitation, criminal sexual abuse, or other violations or crimes that resulted in serious bodily injury; and

''(viii) The number of civil monetary penalties levied against the facility, employees, contractors, and other agents.

''(ix) Any other information that the Secretary determines appropriate.

The facility shall not make available under clause (iv) identifying information on complainants or residents.

''(B) DEADLINE FOR PROVISION OF INFORMATION.—

''(i) IN GENERAL.—Except as provided in clause (ii), the Secretary shall ensure that the information described in subparagraph (A) is included on such website (or a successor website) not later than 1

year after the date of the enactment of this subsection.

''(ii) EXCEPTION.—The Secretary shall ensure that the information described in subparagraph (A)(i) and (A)(iii) is included on such website (or a successor website) not later than 1 year after the dates on which the data are submitted to the Secretary pursuant to section 1124(c)(4) and subsection (b)(8)(C), respectively.

''(2) REVIEW AND MODIFICATION OF WEBSITE.—

''(A) IN GENERAL.—The Secretary shall establish a process—

''(i) to review the accuracy, clarity of presentation, timeliness, and comprehensiveness of information reported on such website as of the day before the date of the enactment of this subsection; and

''(ii) not later than 1 year after the date of the enactment of this subsection, to modify or revamp such website in accordance with the review conducted under clause (i).

''(B) CONSULTATION.—In conducting the review under subparagraph (A)(i), the Secretary shall consult with—

''(i) State long-term care ombudsman programs;

''(ii) consumer advocacy groups;

''(iii) provider stakeholder groups; and

''(iv) any other representatives of programs or groups the Secretary determines appropriate.''.

(2) TIMELINESS OF SUBMISSION OF SURVEY AND CERTIFICATION INFORMATION.—

(A) IN GENERAL.—Section 1819(g)(5) of the Social Security Act (42 U.S.C. 1395i–3(g)(5)) is amended by adding at the end the following new subparagraph:

''(E) SUBMISSION OF SURVEY AND CERTIFICATION INFORMATION TO THE SECRETARY.—In order to improve the timeliness of information made available to the public under subparagraph (A) and provided on the Nursing Home Compare Medicare website under subsection (i), each State shall submit information respecting any survey or certification recommendation made respecting a skilled nursing

facility (including any enforcement actions taken by the State or any Federal enforcement action recommended by the State) to the Secretary not later than the date on which the State sends such information to the facility. The Secretary shall use the information submitted under the preceding sentence to update the information provided on the Nursing Home Compare Medicare website as expeditiously as practicable but not less frequently than quarterly.''.

(B) EFFECTIVE DATE.—The amendment made by this paragraph shall take effect 1 year after the date of the enactment of this Act.

(3) SPECIAL FOCUS FACILITY PROGRAM.—Section 1819(f) of such Act is amended by adding at the end the following new paragraph:

''(8) SPECIAL FOCUS FACILITY PROGRAM.—

''(A) IN GENERAL.—The Secretary shall conduct a special focus facility program for enforcement of requirements for skilled nursing facilities that the Secretary has identified as having a poor compliance history or that substantially failed to meet applicable requirements of this Act

''(B) PERIODIC SURVEYS.—Under such program the Secretary shall conduct surveys of each facility in the program not less than once every 6 months.''.

(b) NURSING FACILITIES.—

(1) IN GENERAL.—Section 1919 of the Social Security Act (42 U.S.C. 1396r) is amended—

(A) by redesignating subsection (i) as subsection (j); and

(B) by inserting after subsection (h) the following new subsection:

''(i) NURSING HOME COMPARE WEBSITE.—

''(1) INCLUSION OF ADDITIONAL INFORMATION.—

''(A) IN GENERAL.—The Secretary shall ensure that the Department of Health and Human Services includes, as part of the information provided for comparison of nursing homes on the official internet website of the Federal Government for Medicare beneficiaries (commonly referred to as the 'Nursing Home Compare' Medicare website) (or a successor website), the following information in a manner that is prominent, easily accessible, readily un-

derstandable to consumers of long-term care services, and searchable:

''(i) Information that is reported to the Secretary under section 1124(c)(4)

''(ii) Information on the 'Special Focus Facility program' (or a successor program) established by the Centers for Medicare & Medicaid Services, according to procedures established by the Secretary. Such procedures shall provide for the inclusion of information with respect to, and the names and locations of, those facilities that, since the previous quarter—

''(I) were newly enrolled in the program;

''(II) are enrolled in the program and have failed to significantly improve;

''(III) are enrolled in the program and have significantly improved;

''(IV) have graduated from the program; and

''(V) have closed voluntarily or no longer participate under this title.

''(iii) Staffing data for each facility (including resident census data and data on the hours of care provided per resident per day) based on data submitted under subsection (b)(8)(C)(ii), including information on staffing turnover and tenure, in a format that is clearly understandable to consumers of long-term care services and allows such consumers to compare differences in staffing between facilities and State and national averages for the facilities. Such format shall include—

''(I) concise explanations of how to interpret the data (such as plain English explanation of data reflecting 'nursing home staff hours per resident day');

''(II) differences in types of staff (such as training associated with different categories of staff);

''(III) the relationship between nurse staffing levels and quality of care; and

''(IV) an explanation that appropriate staffing levels vary based on patient case mix.

''(iv) Links to State internet websites with information regarding State survey and certification programs, links to Form 2567 State inspection reports (or a successor form) on such websites, information to guide consumers in how to interpret and understand such reports, and the facility plan of correction or other response to such report.

''(v) The standardized complaint form developed under subsection (f)(10), including explanatory material on what complaint forms are, how they are used, and how to file a complaint with the State survey and certification program and the State long-term care ombudsman program.

''(vi) Summary information on the number, type, severity, and outcome of substantiated complaints.

''(vii) The number of adjudicated instances of criminal violations by employees of a nursing facility—

''(I) that were committed inside of the facility; and

''(II) with respect to such instances of violations or crimes committed inside of the facility that were the violations or crimes of abuse, neglect, and exploitation, criminal sexual abuse, or other violations or crimes that resulted in serious bodily injury.

''(viii) the number of civil monetary penalties levied against the facility, employees, contractors, and other agents.

''(ix) Any other information that the Secretary determines appropriate.

The facility shall not make available under clause (ii) identifying information about complainants or residents.

''(B) DEADLINE FOR PROVISION OF INFORMATION.—

''(i) IN GENERAL.—Except as provided in clause (ii), the Secretary shall ensure that the information described in subparagraph (A) is included on such website (or a successor website) not later than 1

year after the date of the enactment of this subsection.

''(ii) EXCEPTION.—The Secretary shall ensure that the information described in subparagraph (A)(i) and (A)(iii) is included on such website (or a successor website) not later than 1 year after the dates on which the data are submitted to the Secretary pursuant to section 1124(c)(4) and subsection (b)(8)(C), respectively.

''(2) REVIEW AND MODIFICATION OF WEBSITE.—

''(A) IN GENERAL.—The Secretary shall establish a process—

''(i) to review the accuracy, clarity of presentation, timeliness, and comprehensiveness of information reported on such website as of the day before the date of the enactment of this subsection; and

''(ii) not later than 1 year after the date of the enactment of this subsection, to modify or revamp such website in accordance with the review conducted under clause (i).

''(B) CONSULTATION.—In conducting the review under subparagraph (A)(i), the Secretary shall consult with—

''(i) State long-term care ombudsman programs;

''(ii) consumer advocacy groups;

''(iii) provider stakeholder groups;

''(iv) skilled nursing facility employees and their representatives; and

''(v) any other representatives of programs or groups the Secretary determines appropriate.''.

(2) TIMELINESS OF SUBMISSION OF SURVEY AND CERTIFICATION INFORMATION.—

(A) IN GENERAL.—Section 1919(g)(5) of the Social Security Act (42 U.S.C. 1396r(g)(5)) is amended by adding at the end the following new subparagraph:

''(E) SUBMISSION OF SURVEY AND CERTIFICATION INFORMATION TO THE SECRETARY.—In order to improve the timeliness of information made available to the public under subparagraph (A) and provided on the Nursing Home Compare Medicare website under subsection (i), each State shall submit information

respecting any survey or certification recommendation made respecting a nursing facility (including any enforcement actions taken by the State or any Federal enforcement action recommended by the State) to the Secretary not later than the date on which the State sends such information to the facility. The Secretary shall use the information submitted under the preceding sentence to update the information provided on the Nursing Home Compare Medicare website as expeditiously as practicable but not less frequently than quarterly.''.

(B) EFFECTIVE DATE.—The amendment made by this paragraph shall take effect 1 year after the date of the enactment of this Act.

(3) SPECIAL FOCUS FACILITY PROGRAM.—Section 1919(f) of such Act is amended by adding at the end of the following new paragraph:

''(10) SPECIAL FOCUS FACILITY PROGRAM.—

''(A) IN GENERAL.—The Secretary shall conduct a special focus facility program for enforcement of requirements for nursing facilities that the Secretary has identified as having a poor compliance history or that substantially

failed to meet applicable requirements of this Act

"(B) PERIODIC SURVEYS.—Under such program the Secretary shall conduct surveys of each facility in the program not less often than once every 6 months.".

(c) AVAILABILITY OF REPORTS ON SURVEYS, CERTIFICATIONS, AND COMPLAINT INVESTIGATIONS.—

(1) SKILLED NURSING FACILITIES.—Section 1819(d)(1) of the Social Security Act (42 U.S.C. 1395i–3(d)(1)), as amended by sections 1411 and 1412, is amended by adding at the end the following new subparagraph:

"(D) AVAILABILITY OF SURVEY, CERTIFICATION, AND COMPLAINT INVESTIGATION REPORTS.—A skilled nursing facility must—

"(i) have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years available for any individual to review upon request; and

"(ii) post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public.

The facility shall not make available under clause (i) identifying information about complainants or residents.''.

(2) NURSING FACILITIES.—Section 1919(d)(1) of the Social Security Act (42 U.S.C. 1396r(d)(1)), as amended by sections 1411 and 1412, is amended by adding at the end the following new subparagraph:

''(D) AVAILABILITY OF SURVEY, CERTIFICATION, AND COMPLAINT INVESTIGATION REPORTS.—A nursing facility must—

''(i) have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years available for any individual to review upon request; and

''(ii) post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public.

The facility shall not make available under clause (i) identifying information about complainants or residents.''.

(3) EFFECTIVE DATE.—The amendments made by this subsection shall take effect 1 year after the date of the enactment of this Act.

(d) GUIDANCE TO STATES ON FORM 2567 STATE INSPECTION REPORTS AND COMPLAINT INVESTIGATION REPORTS.—

(1) GUIDANCE.—The Secretary of Health and Human Services (in this subtitle referred to as the ''Secretary'') shall provide guidance to States on how States can establish electronic links to Form 2567 State inspection reports (or a successor form), complaint investigation reports, and a facility's plan of correction or other response to such Form 2567 State inspection reports (or a successor form) on the Internet website of the State that provides information on skilled nursing facilities and nursing facilities and the Secretary shall, if possible, include such information on Nursing Home Compare.

(2) REQUIREMENT.—Section 1902(a)(9) of the Social Security Act (42 U.S.C. 1396a(a)(9)) is amended—

(A) by striking ''and'' at the end of subparagraph (B);

(B) by striking the semicolon at the end of subparagraph (C) and inserting '', and''; and

(C) by adding at the end the following new subparagraph:

''(D) that the State maintain a consumer-oriented website providing useful information to consumers regarding all skilled nursing facilities and all nursing facilities in the State, including for each facility, Form 2567 State inspection reports (or a successor form), complaint investigation reports, the facility's plan of correction, and such other information that the State or the Secretary considers useful in assisting the public to assess the quality of long term care options and the quality of care provided by individual facilities;''.

(3) DEFINITIONS.—In this subsection:

(A) NURSING FACILITY.—The term ''nursing facility'' has the meaning given such term in section 1919(a) of the Social Security Act (42 U.S.C. 1396r(a)).

(B) SECRETARY.—The term ''Secretary'' means the Secretary of Health and Human Services.

(C) SKILLED NURSING FACILITY.—The term ''skilled nursing facility'' has the meaning given such term in section 1819(a) of the Social Security Act (42 U.S.C. 1395i–3(a)).

SEC. 1414. REPORTING OF EXPENDITURES.

Section 1888 of the Social Security Act (42 U.S.C. 1395yy) is amended by adding at the end the following new subsection:

''(f) REPORTING OF DIRECT CARE EXPENDITURES.—

''(1) IN GENERAL.—For cost reports submitted under this title for cost reporting periods beginning on or after the date that is no more than two years after the redesign of the report specified in subparagraph (2), skilled nursing facilities shall—

''(A) separately report expenditures for wages and benefits for direct care staff (breaking out (at a minimum) registered nurses, licensed professional nurses, certified nurse assistants, and other medical and therapy staff); and

''(B) take into account agency and contract staff in a manner to be determined by the Administrator.

''(2) MODIFICATION OF FORM.—The Secretary, in consultation with private sector accountants experienced with skilled nursing facility cost reports, shall redesign such reports to meet the requirement of paragraph (1) not later than 2 years after the date of the enactment of this subsection.

''(3) CATEGORIZATION BY FUNCTIONAL ACCOUNTS.—Beginning with cost reports submitted under paragraph (1) , the Secretary, working in consultation with the Medicare Payment Advisory Commission, the Inspector General of the Department of Health and Human Services, and other expert parties the Secretary determines appropriate, shall categorize the expenditures listed on cost reports, as modified under paragraph (1), submitted by skilled nursing facilities, regardless of any source of payment for such expenditures, for each skilled nursing facility into the following functional accounts on an annual basis:

''(A) Spending on direct care services (including nursing, therapy, and medical services).

''(B) Spending on indirect care (including housekeeping and dietary services).

''(C) Capital assets (including building and land costs).

''(D) Administrative services costs.

''(4) AVAILABILITY OF INFORMATION SUBMITTED.—The Secretary shall establish procedures to make information on expenditures submitted under this subsection readily available to interested parties upon request, subject to such requirements

as the Secretary may specify under the procedures established under this paragraph.''.

SEC. 1415. STANDARDIZED COMPLAINT FORM.

(a) SKILLED NURSING FACILITIES.—

(1) DEVELOPMENT BY THE SECRETARY.—Section 1819(f) of the Social Security Act (42 U.S.C. 1395i–3(f)), as amended by section 1413(a)(3), is amended by adding at the end the following new paragraph:

''(9) STANDARDIZED COMPLAINT FORM.—The Secretary shall develop a standardized complaint form for use by a resident (or a person acting on the resident's behalf) in filing a complaint with a State survey and certification agency and a State long-term care ombudsman program with respect to a skilled nursing facility.''.

(2) STATE REQUIREMENTS.—Section 1819(e) of the Social Security Act (42 U.S.C. 1395i–3(e)) is amended by adding at the end the following new paragraph:

''(6) COMPLAINT PROCESSES AND WHISTLEBLOWER PROTECTION.—

''(A) COMPLAINT FORMS.—The State must make the standardized complaint form devel-

oped under subsection (f)(9) available upon request to—

"(i) a resident of a skilled nursing facility;

"(ii) any person acting on the resident's behalf; and

"(iii) any person who works at a skilled nursing facility or is a representative of such a worker.

"(B) COMPLAINT RESOLUTION PROCESS.—The State must establish a complaint resolution process in order to ensure that a resident, the legal representative of a resident of a skilled nursing facility, or other responsible party is not retaliated against if the resident, legal representative, or responsible party has complained, in good faith, about the quality of care or other issues relating to the skilled nursing facility, that the legal representative of a resident of a skilled nursing facility or other responsible party is not denied access to such resident or otherwise retaliated against if such representative party has complained, in good faith, about the quality of care provided by the facility or other issues relating to the facility,

and that a person who works at a skilled nursing facility is not retaliated against if the worker has complained, in good faith, about quality of care or services or an issue relating to the quality of care or services provided at the facility, whether the resident, legal representative, other responsible party, or worker used the form developed under subsection (f)(9) or some other method for submitting the complaint. Such complaint resolution process shall include—

''(i) procedures to assure accurate tracking of complaints received, including notification to the complainant that a complaint has been received;

''(ii) procedures to determine the likely severity of a complaint and for the investigation of the complaint;

''(iii) deadlines for responding to a complaint and for notifying the complainant of the outcome of the investigation; and

''(iv) procedures to ensure that the identity of the complainant will be kept confidential.

''(C) WHISTLEBLOWER PROTECTION.—

''(i) PROHIBITION AGAINST RETALIATION.—No person who works at a skilled nursing facility may be penalized, discriminated, or retaliated against with respect to any aspect of employment, including discharge, promotion, compensation, terms, conditions, or privileges of employment, or have a contract for services terminated, because the person (or anyone acting at the person's request) complained, in good faith, about the quality of care or services provided by a skilled nursing facility or about other issues relating to quality of care or services, whether using the form developed under subsection (f)(9) or some other method for submitting the complaint.

''(ii) RETALIATORY REPORTING.—A skilled nursing facility may not file a complaint or a report against a person who works (or has worked at the facility) with the appropriate State professional disciplinary agency because the person (or anyone acting at the person's request) complained in good faith, as described in clause (i).

''(iii) RELIEF.—Any person aggrieved by a violation of clause (i) or clause (ii) may, in a civil action, obtain all appropriate relief, including reinstatement, reimbursement of lost wages, compensation, and benefits, and exemplary damages where warranted, and such other relief as the court deems appropriate, as well as costs of suit and reasonable attorney and expert witness fees.

''(iv) RIGHTS NOT WAIVABLE.—The rights protected by this paragraph may not be diminished by contract or other agreement, and nothing in this paragraph shall be construed to diminish any greater or additional protection provided by Federal or State law or by contract or other agreement.

''(v) REQUIREMENT TO POST NOTICE OF EMPLOYEE RIGHTS.—Each skilled nursing facility shall post conspicuously in an appropriate location a sign (in a form specified by the Secretary) specifying the rights of persons under this paragraph and including a statement that an employee

may file a complaint with the Secretary against a skilled nursing facility that violates the provisions of this paragraph and information with respect to the manner of filing such a complaint.

''(D) RULE OF CONSTRUCTION.—Nothing in this paragraph shall be construed as preventing a resident of a skilled nursing facility (or a person acting on the resident's behalf) from submitting a complaint in a manner or format other than by using the standardized complaint form developed under subsection (f)(9) (including submitting a complaint orally).

''(E) GOOD FAITH DEFINED.—For purposes of this paragraph, an individual shall be deemed to be acting in good faith with respect to the filing of a complaint if the individual reasonably believes—

''(i) the information reported or disclosed in the complaint is true; and

''(ii) the violation of this title has occurred or may occur in relation to such information.''.

(b) NURSING FACILITIES.—

(1) DEVELOPMENT BY THE SECRETARY.—Section 1919(f) of the Social Security Act (42 U.S.C. 1395i–3(f)), as amended by section 1413(b), is amended by adding at the end the following new paragraph:

''(11) STANDARDIZED COMPLAINT FORM.—The Secretary shall develop a standardized complaint form for use by a resident (or a person acting on the resident's behalf) in filing a complaint with a State survey and certification agency and a State long-term care ombudsman program with respect to a nursing facility.''.

(2) STATE REQUIREMENTS.—Section 1919(e) of the Social Security Act (42 U.S.C. 1395i–3(e)) is amended by adding at the end the following new paragraph:

''(8) COMPLAINT PROCESSES AND WHISTLEBLOWER PROTECTION.—

''(A) COMPLAINT FORMS.—The State must make the standardized complaint form developed under subsection (f)(11) available upon request to—

''(i) a resident of a nursing facility;

''(ii) any person acting on the resident's behalf; and

''(iii) any person who works at a nursing facility or a representative of such a worker.

''(B) COMPLAINT RESOLUTION PROCESS.—The State must establish a complaint resolution process in order to ensure that a resident, the legal representative of a resident of a nursing facility, or other responsible party is not retaliated against if the resident, legal representative, or responsible party has complained, in good faith, about the quality of care or other issues relating to the nursing facility, that the legal representative of a resident of a nursing facility or other responsible party is not denied access to such resident or otherwise retaliated against if such representative party has complained, in good faith, about the quality of care provided by the facility or other issues relating to the facility, and that a person who works at a nursing facility is not retaliated against if the worker has complained, in good faith, about quality of care or services or an issue relating to the quality of care or services provided at the facility, whether the resident, legal representative, other responsible party, or worker used the

form developed under subsection (f)(11) or some other method for submitting the complaint. Such complaint resolution process shall include—

''(i) procedures to assure accurate tracking of complaints received, including notification to the complainant that a complaint has been received;

''(ii) procedures to determine the likely severity of a complaint and for the investigation of the complaint;

''(iii) deadlines for responding to a complaint and for notifying the complainant of the outcome of the investigation; and

''(iv) procedures to ensure that the identity of the complainant will be kept confidential.

''(C) WHISTLEBLOWER PROTECTION.—

''(i) PROHIBITION AGAINST RETALIATION.—No person who works at a nursing facility may be penalized, discriminated, or retaliated against with respect to any aspect of employment, including discharge, promotion, compensation, terms, condi-

tions, or privileges of employment, or have a contract for services terminated, because the person (or anyone acting at the person's request) complained, in good faith, about the quality of care or services provided by a nursing facility or about other issues relating to quality of care or services, whether using the form developed under subsection (f)(11) or some other method for submitting the complaint.

''(ii) RETALIATORY REPORTING.—A nursing facility may not file a complaint or a report against a person who works (or has worked at the facility with the appropriate State professional disciplinary agency because the person (or anyone acting at the person's request) complained in good faith, as described in clause (i).

''(iii) RELIEF.—Any person aggrieved by a violation of clause (i) or clause (ii) may, in a civil action, obtain all appropriate relief, including reinstatement, reimbursement of lost wages, compensation, and benefits, and exemplary damages where warranted, and such other relief as

the court deems appropriate, as well as costs of suit and reasonable attorney and expert witness fees.

''(iv) RIGHTS NOT WAIVABLE.—The rights protected by this paragraph may not be diminished by contract or other agreement, and nothing in this paragraph shall be construed to diminish any greater or additional protection provided by Federal or State law or by contract or other agreement.

''(v) REQUIREMENT TO POST NOTICE OF EMPLOYEE RIGHTS.—Each nursing facility shall post conspicuously in an appropriate location a sign (in a form specified by the Secretary) specifying the rights of persons under this paragraph and including a statement that an employee may file a complaint with the Secretary against a nursing facility that violates the provisions of this paragraph and information with respect to the manner of filing such a complaint.

''(D) RULE OF CONSTRUCTION.—Nothing in this paragraph shall be construed as pre-

venting a resident of a nursing facility (or a person acting on the resident's behalf) from submitting a complaint in a manner or format other than by using the standardized complaint form developed under subsection (f)(11) (including submitting a complaint orally).

''(E) GOOD FAITH DEFINED.—For purposes of this paragraph, an individual shall be deemed to be acting in good faith with respect to the filing of a complaint if the individual reasonably believes—

''(i) the information reported or disclosed in the complaint is true; and

''(ii) the violation of this title has occurred or may occur in relation to such information.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall take effect 1 year after the date of the enactment of this Act.

SEC. 1416. ENSURING STAFFING ACCOUNTABILITY.

(a) SKILLED NURSING FACILITIES.—Section 1819(b)(8) of the Social Security Act (42 U.S.C. 1395i–3(b)(8)) is amended by adding at the end the following new subparagraph:

''(C) SUBMISSION OF STAFFING INFORMATION BASED ON PAYROLL DATA IN A UNIFORM FORMAT.—On and after the first day of the first calendar quarter beginning after the date that is 2 years after the date of enactment of this subparagraph, and after consulting with State long-term care ombudsman programs, consumer advocacy groups, provider stakeholder groups, employees and their representatives, and other parties the Secretary deems appropriate, the Secretary shall require a skilled nursing facility to electronically submit to the Secretary direct care staffing information (including information with respect to agency and contract staff) based on payroll and other verifiable and auditable data in a uniform format (according to specifications established by the Secretary in consultation with such programs, groups, and parties). Such specifications shall require that the information submitted under the preceding sentence—

''(i) specify the category of work a certified employee performs (such as whether the employee is a registered nurse, licensed practical nurse, licensed vocational

nurse, certified nursing assistant, therapist, or other medical personnel);

''(ii) include resident census data and information on resident case mix;

''(iii) include a regular reporting schedule; and

''(iv) include information on employee turnover and tenure and on the hours of care provided by each category of certified employees referenced in clause (i) per resident per day.

Nothing in this subparagraph shall be construed as preventing the Secretary from requiring submission of such information with respect to specific categories, such as nursing staff, before other categories of certified employees. Information under this subparagraph with respect to agency and contract staff shall be kept separate from information on employee staffing.''.

(b) NURSING FACILITIES.—Section 1919(b)(8) of the Social Security Act (42 U.S.C. 1396r(b)(8)) is amended by adding at the end the following new subparagraph:

''(C) SUBMISSION OF STAFFING INFORMATION BASED ON PAYROLL DATA IN A UNIFORM FORMAT.—On and after the first day of the

first calendar quarter beginning after the date that is 2 years after the date of enactment of this subparagraph, and after consulting with State long-term care ombudsman programs, consumer advocacy groups, provider stakeholder groups, employees and their representatives, and other parties the Secretary deems appropriate, the Secretary shall require a nursing facility to electronically submit to the Secretary direct care staffing information (including information with respect to agency and contract staff) based on payroll and other verifiable and auditable data in a uniform format (according to specifications established by the Secretary in consultation with such programs, groups, and parties). Such specifications shall require that the information submitted under the preceding sentence—

''(i) specify the category of work a certified employee performs (such as whether the employee is a registered nurse, licensed practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other medical personnel);

''(ii) include resident census data and information on resident case mix;

''(iii) include a regular reporting schedule; and

''(iv) include information on employee turnover and tenure and on the hours of care provided by each category of certified employees referenced in clause (i) per resident per day.

Nothing in this subparagraph shall be construed as preventing the Secretary from requiring submission of such information with respect to specific categories, such as nursing staff, before other categories of certified employees. Information under this subparagraph with respect to agency and contract staff shall be kept separate from information on employee staffing.''.

SEC. 1417. NATIONWIDE PROGRAM FOR NATIONAL AND STATE BACKGROUND CHECKS ON DIRECT PATIENT ACCESS EMPLOYEES OF LONG-TERM CARE FACILITIES AND PROVIDERS.

(a) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary''), shall establish a program to identify efficient, effective, and economical procedures for long term care fa-

cilities or providers to conduct background checks on prospective direct patient access employees on a nationwide basis (in this subsection, such program shall be referred to as the ''nationwide program''). The Secretary shall carry out the nationwide program under similar terms and conditions as the pilot program under section 307 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173; 117 Stat. 2257), including the prohibition on hiring abusive workers and the authorization of the imposition of penalties by a participating State under subsections (b)(3)(A) and (b)(6), respectively, of such section 307. The program under this subsection shall contain the following modifications to such pilot program:

(1) AGREEMENTS.—

(A) NEWLY PARTICIPATING STATES.—The Secretary shall enter into agreements with each State—

(i) that the Secretary has not entered into an agreement with under subsection (c)(1) of such section 307;

(ii) that agrees to conduct background checks under the nationwide program on a Statewide basis; and

(iii) that submits an application to the Secretary containing such information and at such time as the Secretary may specify.

(B) CERTAIN PREVIOUSLY PARTICIPATING STATES.—The Secretary shall enter into agreements with each State—

(i) that the Secretary has entered into an agreement with under such subsection (c)(1);

(ii) that agrees to conduct background checks under the nationwide program on a Statewide basis; and

(iii) that submits an application to the Secretary containing such information and at such time as the Secretary may specify.

(2) NONAPPLICATION OF SELECTION CRITERIA.—The selection criteria required under subsection (c)(3)(B) of such section 307 shall not apply.

(3) REQUIRED FINGERPRINT CHECK AS PART OF CRIMINAL BACKGROUND CHECK.—The procedures established under subsection (b)(1) of such section 307 shall—

(A) require that the long-term care facility or provider (or the designated agent of the long-term care facility or provider) obtain State

and national criminal or other background checks on the prospective employee through such means as the Secretary determines appropriate that utilize a search of State-based abuse and neglect registries and databases, including the abuse and neglect registries of another State in the case where a prospective employee previously resided in that State, State criminal history records, the records of any proceedings in the State that may contain disqualifying information about prospective employees (such as proceedings conducted by State professional licensing and disciplinary boards and State Medicaid Fraud Control Units), and Federal criminal history records, including a fingerprint check using the Integrated Automated Fingerprint Identification System of the Federal Bureau of Investigation; and

(B) require States to describe and test methods that reduce duplicative fingerprinting, including providing for the development of ''rap back'' capability by the State such that, if a direct patient access employee of a long-term care facility or provider is convicted of a crime following the initial criminal history background

check conducted with respect to such employee, and the employee's fingerprints match the prints on file with the State law enforcement department, the department will immediately inform the State and the State will immediately inform the long-term care facility or provider which employs the direct patient access employee of such conviction.

(4) STATE REQUIREMENTS.—An agreement entered into under paragraph (1) shall require that a participating State—

(A) be responsible for monitoring compliance with the requirements of the nationwide program;

(B) have procedures in place to—

(i) conduct screening and criminal or other background checks under the nationwide program in accordance with the requirements of this section;

(ii) monitor compliance by long-term care facilities and providers with the procedures and requirements of the nationwide program;

(iii) as appropriate, provide for a provisional period of employment by a long-

term care facility or provider of a direct patient access employee, not to exceed 60 days, pending completion of the required criminal history background check and, in the case where the employee has appealed the results of such background check, pending completion of the appeals process, during which the employee shall be subject to direct on-site supervision (in accordance with procedures established by the State to ensure that a long-term care facility or provider furnishes such direct on-site supervision);

(iv) provide an independent process by which a provisional employee or an employee may appeal or dispute the accuracy of the information obtained in a background check performed under the nationwide program, including the specification of criteria for appeals for direct patient access employees found to have disqualifying information which shall include consideration of the passage of time, extenuating circumstances, demonstration of rehabilitation, and relevancy of the particular dis-

qualifying information with respect to the current employment of the individual;

(v) provide for the designation of a single State agency as responsible for—

(I) overseeing the coordination of any State and national criminal history background checks requested by a long-term care facility or provider (or the designated agent of the long-term care facility or provider) utilizing a search of State and Federal criminal history records, including a fingerprint check of such records;

(II) overseeing the design of appropriate privacy and security safeguards for use in the review of the results of any State or national criminal history background checks conducted regarding a prospective direct patient access employee to determine whether the employee has any conviction for a relevant crime;

(III) immediately reporting to the long-term care facility or provider that requested the criminal history

background check the results of such review; and

(IV) in the case of an employee with a conviction for a relevant crime that is subject to reporting under section 1128E of the Social Security Act (42 U.S.C. 1320a–7e), reporting the existence of such conviction to the database established under that section;

(vi) determine which individuals are direct patient access employees (as defined in paragraph (6)(B)) for purposes of the nationwide program;

(vii) as appropriate, specify offenses, including convictions for violent crimes, for purposes of the nationwide program; and

(viii) describe and test methods that reduce duplicative fingerprinting, including providing for the development of ''rap back'' capability such that, if a direct patient access employee of a long-term care facility or provider is convicted of a crime following the initial criminal history background check conducted with respect to

such employee, and the employee's fingerprints match the prints on file with the State law enforcement department—

(I) the department will immediately inform the State agency designated under clause (v) and such agency will immediately inform the facility or provider which employs the direct patient access employee of such conviction; and

(II) the State will provide, or will require the facility to provide, to the employee a copy of the results of the criminal history background check conducted with respect to the employee at no charge in the case where the individual requests such a copy.

Background checks and screenings under this subsection shall be valid for a period of no longer than 2 years, as determined by the State and approved by the Secretary.

(5) PAYMENTS.—

(A) NEWLY PARTICIPATING STATES.—

(i) IN GENERAL.—As part of the application submitted by a State under paragraph (1)(A)(iii), the State shall guarantee, with respect to the costs to be incurred by the State in carrying out the nationwide program, that the State will make available (directly or through donations from public or private entities) a particular amount of non-Federal contributions, as a condition of receiving the Federal match under clause (ii).

(ii) FEDERAL MATCH.—The payment amount to each State that the Secretary enters into an agreement with under paragraph (1)(A) shall be 3 times the amount that the State guarantees to make available under clause (i).

(B) PREVIOUSLY PARTICIPATING STATES.—

(i) IN GENERAL.—As part of the application submitted by a State under paragraph (1)(B)(iii), the State shall guarantee, with respect to the costs to be incurred by the State in carrying out the nationwide program, that the State will make

available (directly or through donations from public or private entities) a particular amount of non-Federal contributions, as a condition of receiving the Federal match under clause (ii).

(ii) FEDERAL MATCH.—The payment amount to each State that the Secretary enters into an agreement with under paragraph (1)(B) shall be 3 times the amount that the State guarantees to make available under clause (i).

(6) DEFINITIONS.—Under the nationwide program:

(A) LONG-TERM CARE FACILITY OR PROVIDER.—The term ''long-term care facility or provider'' means the following facilities or providers which receive payment for services under title XVIII or XIX of the Social Security Act:

(i) A skilled nursing facility (as defined in section 1819(a) of the Social Security Act (42 U.S.C. 1395i–3(a))).

(ii) A nursing facility (as defined in section 1919(a) of such Act (42 U.S.C. 1396r(a))).

(iii) A home health agency.

(iv) A provider of hospice care (as defined in section 1861(dd)(1) of such Act (42 U.S.C. 1395x(dd)(1))).

(v) A long-term care hospital (as described in section 1886(d)(1)(B)(iv) of such Act (42 U.S.C. 1395ww(d)(1)(B)(iv))).

(vi) A provider of personal care services.

(vii) A provider of adult day care.

(viii) A residential care provider that arranges for, or directly provides, long-term care services, including an assisted living facility that provides a nursing home level of care conveyed by State licensure or State definition.

(ix) An intermediate care facility for the mentally retarded (as defined in section 1905(d) of such Act (42 U.S.C. 1396d(d))).

(x) Any other facility or provider of long-term care services under such titles as the participating State determines appropriate.

(B) DIRECT PATIENT ACCESS EMPLOYEE.—The term ''direct patient access employee'' means any individual who has access to a patient or resident of a long-term care facility or provider through employment or through a contract with such facility or provider and has duties that involve (or may involve) one-on-one contact with a patient or resident of the facility or provider, as determined by the State for purposes of the nationwide program. Such term does not include a volunteer unless the volunteer has duties that are equivalent to the duties of a direct patient access employee and those duties involve (or may involve) one-on-one contact with a patient or resident of the long-term care facility or provider.

(7) EVALUATION AND REPORT.—

(A) EVALUATION.—The Inspector General of the Department of Health and Human Services shall conduct an evaluation of the nationwide program. Such evaluation shall include—

(i) a review of the various procedures implemented by participating States for long-term care facilities or providers, including staffing agencies, to conduct back-

ground checks of direct patient access employees and identify the most efficient, effective, and economical procedures for conducting such background checks;

(ii) an assessment of the costs of conducting such background checks (including start-up and administrative costs);

(iii) a determination of the extent to which conducting such background checks leads to any unintended consequences, including a reduction in the available workforce for such facilities or providers;

(iv) an assessment of the impact of the program on reducing the number of incidents of neglect, abuse, and misappropriation of resident property to the extent practicable; and

(v) an evaluation of other aspects of the program, as determined appropriate by the Secretary.

(B) REPORT.—Not later than 180 days after the completion of the nationwide program, the Inspector General of the Department of Health and Human Services shall submit a re-

port to Congress containing the results of the evaluation conducted under subparagraph (A).

(b) FUNDING.—

(1) NOTIFICATION.—The Secretary of Health and Human Services shall notify the Secretary of the Treasury of the amount necessary to carry out the nationwide program under this section, including costs for the Department of Health and Human Services to administer and evaluate the program, for the period of fiscal years 2010 through 2012, except that in no case shall such amount exceed $160,000,000.

(2) TRANSFER OF FUNDS.—Out of any funds in the Treasury not otherwise appropriated, the Secretary of the Treasury shall provide for the transfer to the Secretary of Health and Human Services of the amount specified as necessary to carry out the nationwide program under paragraph (1). Such amount shall remain available until expended.

PART 2—TARGETING ENFORCEMENT

SEC. 1421. CIVIL MONEY PENALTIES.

(a) SKILLED NURSING FACILITIES.—

(1) IN GENERAL.—Section 1819(h)(2)(B)(ii) of the Social Security Act (42 U.S.C. 1395i–3(h)(2)(B)(ii)) is amended to read as follows:

''(ii) AUTHORITY WITH RESPECT TO CIVIL MONEY PENALTIES.—

''(I) AMOUNT.—The Secretary may impose a civil money penalty in the applicable per instance or per day amount (as defined in subclause (II) and (III)) for each day or instance, respectively, of noncompliance (as determined appropriate by the Secretary).

''(II) APPLICABLE PER INSTANCE AMOUNT.—In this clause, the term 'applicable per instance amount' means—

''(aa) in the case where the deficiency is found to be a direct proximate cause of death of a resident of the facility, an amount not to exceed $100,000.

''(bb) in each case of a deficiency where the facility is cited for actual harm or immediate jeopardy, an amount not less than $3,050 and not more than $25,000; and

"(cc) in each case of any other deficiency, an amount not less than $250 and not to exceed $3050.

"(III) APPLICABLE PER DAY AMOUNT.—In this clause, the term 'applicable per day amount' means—

"(aa) in each case of a deficiency where the facility is cited for actual harm or immediate jeopardy, an amount not less than $3,050 and not more than $25,000 and

"(bb) in each case of any other deficiency, an amount not less than $250 and not to exceed $3,050.

"(IV) REDUCTION OF CIVIL MONEY PENALTIES IN CERTAIN CIRCUMSTANCES.—Subject to subclauses (V) and (VI), in the case where a facility self-reports and promptly corrects a deficiency for which a penalty was imposed under this clause not later than 10 calendar days after the

date of such imposition, the Secretary may reduce the amount of the penalty imposed by not more than 50 percent.

''(V) PROHIBITION ON REDUCTION FOR CERTAIN DEFICIENCIES.—

''(aa) REPEAT DEFICIENCIES.—The Secretary may not reduce under subclause (IV) the amount of a penalty if the deficiency is a repeat deficiency.

''(bb) CERTAIN OTHER DEFICIENCIES.—The Secretary may not reduce under subclause (IV) the amount of a penalty if the penalty is imposed for a deficiency described in subclause (II)(aa) or (III)(aa) and the actual harm or widespread harm immediately jeopardizes the health or safety of a resident or residents of the facility, or if the penalty is imposed for a deficiency described in subclause (II)(bb).

''(VI) LIMITATION ON AGGREGATE REDUCTIONS.—The aggregate reduction in a penalty under subclause (IV) may not exceed 35 percent on the basis of self-reporting, on the basis of a waiver of an appeal (as provided for under regulations under section 488.436 of title 42, Code of Federal Regulations), or on the basis of both.

''(VII) COLLECTION OF CIVIL MONEY PENALTIES.—In the case of a civil money penalty imposed under this clause, the Secretary—

''(aa) subject to item (cc), shall, not later than 30 days after the date of imposition of the penalty, provide the opportunity for the facility to participate in an independent informal dispute resolution process, established by the State survey agency, which generates a written record prior to the collection of such penalty, but such oppor-

tunity shall not affect the responsibility of the State survey agency for making final recommendations for such penalties;

''(bb) in the case where the penalty is imposed for each day of noncompliance, shall not impose a penalty for any day during the period beginning on the initial day of the imposition of the penalty and ending on the day on which the informal dispute resolution process under item (aa) is completed;

''(cc) may provide for the collection of such civil money penalty and the placement of such amounts collected in an escrow account under the direction of the Secretary on the earlier of the date on which the informal dispute resolution process under item (aa) is completed or the date that is 90 days after the

date of the imposition of the penalty;

''(dd) may provide that such amounts collected are kept in such account pending the resolution of any subsequent appeals;

''(ee) in the case where the facility successfully appeals the penalty, may provide for the return of such amounts collected (plus interest) to the facility; and

''(ff) in the case where all such appeals are unsuccessful, may provide that some portion of such amounts collected may be used to support activities that benefit residents, including assistance to support and protect residents of a facility that closes (voluntarily or involuntarily) or is decertified (including offsetting costs of relocating residents to home and community-based settings or another facility), projects that support resident and family

councils and other consumer involvement in assuring quality care in facilities, and facility improvement initiatives approved by the Secretary (including joint training of facility staff and surveyors, technical assistance for facilities under quality assurance programs, the appointment of temporary management, and other activities approved by the Secretary).

''(VIII) PROCEDURE.—The provisions of section 1128A (other than subsections (a) and (b) and except to the extent that such provisions require a hearing prior to the imposition of a civil money penalty) shall apply to a civil money penalty under this clause in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).''.

(2) CONFORMING AMENDMENT.—The second sentence of section 1819(h)(5) of the Social Security

Act (42 U.S.C. 1395i–3(h)(5)) is amended by inserting ''(ii),''after ''(i),''.

(b) NURSING FACILITIES.—

(1) PENALTIES IMPOSED BY THE STATE.—

(A) IN GENERAL.—Section 1919(h)(2) of the Social Security Act (42 U.S.C. 1396r(h)(2)) is amended—

(i) in subparagraph (A)(ii), by striking the first sentence and inserting the following: ''A civil money penalty in accordance with subparagraph (G).''; and

(ii) by adding at the end the following new subparagraph:

''(G) CIVIL MONEY PENALTIES.—

''(i) IN GENERAL.—The State may impose a civil money penalty under subparagraph (A)(ii) in the applicable per instance or per day amount (as defined in subclause (II) and (III)) for each day or instance, respectively, of noncompliance (as determined appropriate by the Secretary).

''(ii) APPLICABLE PER INSTANCE AMOUNT.—In this subparagraph, the term 'applicable per instance amount' means—

''(I) in the case where the deficiency is found to be a direct proximate cause of death of a resident of the facility, an amount not to exceed $100,000.

''(II) in each case of a deficiency where the facility is cited for actual harm or immediate jeopardy, an amount not less than $3,050 and not more than $25,000; and

''(III) in each case of any other deficiency, an amount not less than $250 and not to exceed $3050.

''(iii) APPLICABLE PER DAY AMOUNT.—In this subparagraph, the term 'applicable per day amount' means—

''(I) in each case of a deficiency where the facility is cited for actual harm or immediate jeopardy, an amount not less than $3,050 and not more than $25,000 and

''(II) in each case of any other deficiency, an amount not less than $250 and not to exceed $3,050.

''(iv) REDUCTION OF CIVIL MONEY PENALTIES IN CERTAIN CIRCUMSTANCES.—Subject to clauses (v) and (vi), in the case where a facility self-reports and promptly corrects a deficiency for which a penalty was imposed under subparagraph (A)(ii) not later than 10 calendar days after the date of such imposition, the State may reduce the amount of the penalty imposed by not more than 50 percent.

''(v) PROHIBITION ON REDUCTION FOR CERTAIN DEFICIENCIES.—

''(I) REPEAT DEFICIENCIES.—The State may not reduce under clause (iv) the amount of a penalty if the State had reduced a penalty imposed on the facility in the preceding year under such clause with respect to a repeat deficiency.

''(II) CERTAIN OTHER DEFICIENCIES.—The State may not reduce under clause (iv) the amount of a penalty if the penalty is imposed for a deficiency described in clause (ii)(II) or

(iii)(I) and the actual harm or widespread harm that immediately jeopardizes the health or safety of a resident or residents of the facility, or if the penalty is imposed for a deficiency described in clause (ii)(I).

''(III) LIMITATION ON AGGREGATE REDUCTIONS.—The aggregate reduction in a penalty under clause (iv) may not exceed 35 percent on the basis of self-reporting, on the basis of a waiver of an appeal (as provided for under regulations under section 488.436 of title 42, Code of Federal Regulations), or on the basis of both.

''(vi) COLLECTION OF CIVIL MONEY PENALTIES.—In the case of a civil money penalty imposed under subparagraph (A)(ii), the State—

''(I) subject to subclause (III), shall, not later than 30 days after the date of imposition of the penalty, provide the opportunity for the facility to participate in an independent informal dispute resolution process, established

by the State survey agency, which generates a written record prior to the collection of such penalty, but such opportunity shall not affect the responsibility of the State survey agency for making final recommendations for such penalties;

''(II) in the case where the penalty is imposed for each day of noncompliance, shall not impose a penalty for any day during the period beginning on the initial day of the imposition of the penalty and ending on the day on which the informal dispute resolution process under subclause (I) is completed;

''(III) may provide for the collection of such civil money penalty and the placement of such amounts collected in an escrow account under the direction of the State on the earlier of the date on which the informal dispute resolution process under subclause (I) is completed or the date

that is 90 days after the date of the imposition of the penalty;

''(IV) may provide that such amounts collected are kept in such account pending the resolution of any subsequent appeals;

''(V) in the case where the facility successfully appeals the penalty, may provide for the return of such amounts collected (plus interest) to the facility; and

''(VI) in the case where all such appeals are unsuccessful, may provide that such funds collected shall be used for the purposes described in the second sentence of subparagraph (A)(ii).''.

(B) CONFORMING AMENDMENT.—The second sentence of section 1919(h)(2)(A)(ii) of the Social Security Act (42 U.S.C. 1396r(h)(2)(A)(ii)) is amended by inserting before the period at the end the following: '', and some portion of such funds may be used to support activities that benefit residents, including assistance to support and protect residents of a

facility that closes (voluntarily or involuntarily) or is decertified (including offsetting costs of relocating residents to home and community-based settings or another facility), projects that support resident and family councils and other consumer involvement in assuring quality care in facilities, and facility improvement initiatives approved by the Secretary (including joint training of facility staff and surveyors, providing technical assistance to facilities under quality assurance programs, the appointment of temporary management, and other activities approved by the Secretary)''.

(2) PENALTIES IMPOSED BY THE SECRETARY.—

(A) IN GENERAL.—Section 1919(h)(3)(C)(ii) of the Social Security Act (42 U.S.C. 1396r(h)(3)(C)) is amended to read as follows:

''(ii) AUTHORITY WITH RESPECT TO CIVIL MONEY PENALTIES.—

''(I) AMOUNT.—Subject to subclause (II), the Secretary may impose a civil money penalty in an amount not to exceed $10,000 for each day or

each instance of noncompliance (as determined appropriate by the Secretary).

''(II) REDUCTION OF CIVIL MONEY PENALTIES IN CERTAIN CIRCUMSTANCES.—Subject to subclause (III), in the case where a facility self-reports and promptly corrects a deficiency for which a penalty was imposed under this clause not later than 10 calendar days after the date of such imposition, the Secretary may reduce the amount of the penalty imposed by not more than 50 percent.

''(III) PROHIBITION ON REDUCTION FOR REPEAT DEFICIENCIES.—The Secretary may not reduce the amount of a penalty under subclause (II) if the Secretary had reduced a penalty imposed on the facility in the preceding year under such subclause with respect to a repeat deficiency.

''(IV) COLLECTION OF CIVIL MONEY PENALTIES.—In the case of a

civil money penalty imposed under this clause, the Secretary—

"(aa) subject to item (bb), shall, not later than 30 days after the date of imposition of the penalty, provide the opportunity for the facility to participate in an independent informal dispute resolution process which generates a written record prior to the collection of such penalty;

"(bb) in the case where the penalty is imposed for each day of noncompliance, shall not impose a penalty for any day during the period beginning on the initial day of the imposition of the penalty and ending on the day on which the informal dispute resolution process under item (aa) is completed;

"(cc) may provide for the collection of such civil money penalty and the placement of such amounts collected in an es-

crow account under the direction of the Secretary on the earlier of the date on which the informal dispute resolution process under item (aa) is completed or the date that is 90 days after the date of the imposition of the penalty;

''(dd) may provide that such amounts collected are kept in such account pending the resolution of any subsequent appeals;

''(ee) in the case where the facility successfully appeals the penalty, may provide for the return of such amounts collected (plus interest) to the facility; and

''(ff) in the case where all such appeals are unsuccessful, may provide that some portion of such amounts collected may be used to support activities that benefit residents, including assistance to support and protect residents of a facility that closes

(voluntarily or involuntarily) or is decertified (including offsetting costs of relocating residents to home and community-based settings or another facility), projects that support resident and family councils and other consumer involvement in assuring quality care in facilities, and facility improvement initiatives approved by the Secretary (including joint training of facility staff and surveyors, technical assistance for facilities under quality assurance programs, the appointment of temporary management, and other activities approved by the Secretary).

''(V) PROCEDURE.—The provisions of section 1128A (other than subsections (a) and (b) and except to the extent that such provisions require a hearing prior to the imposition of a civil money penalty) shall apply to a civil money penalty under this clause

in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).''.

(B) CONFORMING AMENDMENT.—Section 1919(h)(8) of the Social Security Act (42 U.S.C. 1396r(h)(5)(8)) is amended by inserting ''and in paragraph (3)(C)(ii)'' after ''paragraph (2)(A)''.

(c) EFFECTIVE DATE.—The amendments made by this section shall take effect 1 year after the date of the enactment of this Act.

SEC. 1422. NATIONAL INDEPENDENT MONITOR PILOT PROGRAM.

(a) ESTABLISHMENT.—

(1) IN GENERAL.—The Secretary, in consultation with the Inspector General of the Department of Health and Human Services, shall establish a pilot program (in this section referred to as the ''pilot program'') to develop, test, and implement use of an independent monitor to oversee interstate and large intrastate chains of skilled nursing facilities and nursing facilities.

(2) SELECTION.—The Secretary shall select chains of skilled nursing facilities and nursing facilities described in paragraph (1) to participate in the

pilot program from among those chains that submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require.

(3) DURATION.—The Secretary shall conduct the pilot program for a two-year period.

(4) IMPLEMENTATION.—The Secretary shall implement the pilot program not later than one year after the date of the enactment of this Act.

(b) REQUIREMENTS.—The Secretary shall evaluate chains selected to participate in the pilot program based on criteria selected by the Secretary, including where evidence suggests that one or more facilities of the chain are experiencing serious safety and quality of care problems. Such criteria may include the evaluation of a chain that includes one or more facilities participating in the ''Special Focus Facility'' program (or a successor program) or one or more facilities with a record of repeated serious safety and quality of care deficiencies.

(c) RESPONSIBILITIES OF THE INDEPENDENT MONITOR.—An independent monitor that enters into a contract with the Secretary to participate in the conduct of such program shall—

(1) conduct periodic reviews and prepare root-cause quality and deficiency analyses of a chain to

assess if facilities of the chain are in compliance with State and Federal laws and regulations applicable to the facilities;

(2) undertake sustained oversight of the chain, whether publicly or privately held, to involve the owners of the chain and the principal business partners of such owners in facilitating compliance by facilities of the chain with State and Federal laws and regulations applicable to the facilities;

(3) analyze the management structure, distribution of expenditures, and nurse staffing levels of facilities of the chain in relation to resident census, staff turnover rates, and tenure;

(4) report findings and recommendations with respect to such reviews, analyses, and oversight to the chain and facilities of the chain, to the Secretary and to relevant States; and

(5) publish the results of such reviews, analyses, and oversight.

(d) IMPLEMENTATION OF RECOMMENDATIONS.—

(1) RECEIPT OF FINDING BY CHAIN.—Not later than 10 days after receipt of a finding of an independent monitor under subsection (c)(4), a chain participating in the pilot program shall submit to the independent monitor a report—

(A) outlining corrective actions the chain will take to implement the recommendations in such report; or

(B) indicating that the chain will not implement such recommendations and why it will not do so.

(2) RECEIPT OF REPORT BY INDEPENDENT MONITOR.—Not later than 10 days after the date of receipt of a report submitted by a chain under paragraph (1), an independent monitor shall finalize its recommendations and submit a report to the chain and facilities of the chain, the Secretary, and the State (or States) involved, as appropriate, containing such final recommendations.

(e) COST OF APPOINTMENT.—A chain shall be responsible for a portion of the costs associated with the appointment of independent monitors under the pilot program. The chain shall pay such portion to the Secretary (in an amount and in accordance with procedures established by the Secretary).

(f) WAIVER AUTHORITY.—The Secretary may waive such requirements of titles XVIII and XIX of the Social Security Act (42 U.S.C. 1395 et seq.; 1396 et seq.) as may be necessary for the purpose of carrying out the pilot program.

(g) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as may be necessary to carry out this section.

(h) DEFINITIONS.—In this section:

(1) FACILITY.—The term ''facility'' means a skilled nursing facility or a nursing facility.

(2) NURSING FACILITY.—The term ''nursing facility'' has the meaning given such term in section 1919(a) of the Social Security Act (42 U.S.C. 1396r(a)).

(3) SECRETARY.—The term ''Secretary'' means the Secretary of Health and Human Services, acting through the Assistant Secretary for Planning and Evaluation.

(4) SKILLED NURSING FACILITY.—The term ''skilled nursing facility'' has the meaning given such term in section 1819(a) of the Social Security Act (42 U.S.C. 1395(a)).

(i) EVALUATION AND REPORT.—

(1) EVALUATION.—The Inspector General of the Department of Health and Human Services shall evaluate the pilot program. Such evaluation shall—

(A) determine whether the independent monitor program should be established on a permanent basis; and

(B) if the Inspector General determines that the independent monitor program should be established on a permanent basis, recommend appropriate procedures and mechanisms for such establishment.

(2) REPORT.—Not later than 180 days after the completion of the pilot program, the Inspector General shall submit to Congress and the Secretary a report containing the results of the evaluation conducted under paragraph (1), together with recommendations for such legislation and administrative action as the Inspector General determines appropriate.

SEC. 1423. NOTIFICATION OF FACILITY CLOSURE.

(a) SKILLED NURSING FACILITIES.—

(1) IN GENERAL.—Section 1819(c) of the Social Security Act (42 U.S.C. 1395i–3(c)) is amended by adding at the end the following new paragraph:

''(7) NOTIFICATION OF FACILITY CLOSURE.—

''(A) IN GENERAL.—Any individual who is the administrator of a skilled nursing facility must—

''(i) submit to the Secretary, the State long-term care ombudsman, residents of the facility, and the legal representatives of

such residents or other responsible parties, written notification of an impending closure—

''(I) subject to subclause (II), not later than the date that is 60 days prior to the date of such closure; and

''(II) in the case of a facility where the Secretary terminates the facility's participation under this title, not later than the date that the Secretary determines appropriate;

''(ii) ensure that the facility does not admit any new residents on or after the date on which such written notification is submitted; and

''(iii) include in the notice a plan for the transfer and adequate relocation of the residents of the facility by a specified date prior to closure that has been approved by the State, including assurances that the residents will be transferred to the most appropriate facility or other setting in terms of quality, services, and location, taking into consideration the needs and best interests of each resident.

''(B) RELOCATION.—

''(i) IN GENERAL.—The State shall ensure that, before a facility closes, all residents of the facility have been successfully relocated to another facility or an alternative home and community-based setting.

''(ii) CONTINUATION OF PAYMENTS UNTIL RESIDENTS RELOCATED.—The Secretary may, as the Secretary determines appropriate, continue to make payments under this title with respect to residents of a facility that has submitted a notification under subparagraph (A) during the period beginning on the date such notification is submitted and ending on the date on which the resident is successfully relocated.''.

(2) CONFORMING AMENDMENTS.—Section 1819(h)(4) of the Social Security Act (42 U.S.C. 1395i–3(h)(4)) is amended—

(A) in the first sentence, by striking ''the Secretary shall terminate'' and inserting ''the Secretary, subject to subsection (c)(7), shall terminate''; and

(B) in the second sentence, by striking ''subsection (c)(2)'' and inserting ''paragraphs (2) and (7) of subsection (c)''.

(b) NURSING FACILITIES.—

(1) IN GENERAL.—Section 1919(c) of the Social Security Act (42 U.S.C. 1396r(c)) is amended by adding at the end the following new paragraph:

''(9) NOTIFICATION OF FACILITY CLOSURE.—

''(A) IN GENERAL.—Any individual who is an administrator of a nursing facility must—

''(i) submit to the Secretary, the State long-term care ombudsman, residents of the facility, and the legal representatives of such residents or other responsible parties, written notification of an impending closure—

''(I) subject to subclause (II), not later than the date that is 60 days prior to the date of such closure; and

''(II) in the case of a facility where the Secretary terminates the facility's participation under this title, not later than the date that the Secretary determines appropriate;

''(ii) ensure that the facility does not admit any new residents on or after the date on which such written notification is submitted; and

''(iii) include in the notice a plan for the transfer and adequate relocation of the residents of the facility by a specified date prior to closure that has been approved by the State, including assurances that the residents will be transferred to the most appropriate facility or other setting in terms of quality, services, and location, taking into consideration the needs and best interests of each resident.

''(B) RELOCATION.—

''(i) IN GENERAL.—The State shall ensure that, before a facility closes, all residents of the facility have been successfully relocated to another facility or an alternative home and community-based setting.

''(ii) CONTINUATION OF PAYMENTS UNTIL RESIDENTS RELOCATED.—The Secretary may, as the Secretary determines appropriate, continue to make payments

under this title with respect to residents of a facility that has submitted a notification under subparagraph (A) during the period beginning on the date such notification is submitted and ending on the date on which the resident is successfully relocated.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall take effect 1 year after the date of the enactment of this Act.

PART 3—IMPROVING STAFF TRAINING

SEC. 1431. DEMENTIA AND ABUSE PREVENTION TRAINING.

(a) SKILLED NURSING FACILITIES.—Section 1819(f)(2)(A)(i)(I) of the Social Security Act (42 U.S.C. 1395i–3(f)(2)(A)(i)(I)) is amended by inserting ''(including, in the case of initial training and, if the Secretary determines appropriate, in the case of ongoing training, dementia management training and resident abuse prevention training)'' after ''curriculum''.

(b) NURSING FACILITIES.—Section 1919(f)(2)(A)(i)(I) of the Social Security Act (42 U.S.C. 1396r(f)(2)(A)(i)(I)) is amended by inserting ''(including, in the case of initial training and, if the Secretary determines appropriate, in the case of ongoing training, dementia management training and resident abuse prevention training)'' after ''curriculum''.

(c) EFFECTIVE DATE.—The amendments made by this section shall take effect 1 year after the date of the enactment of this Act.

SEC. 1432. STUDY AND REPORT ON TRAINING REQUIRED FOR CERTIFIED NURSE AIDES AND SUPERVISORY STAFF.

(a) STUDY.—

(1) IN GENERAL.—The Secretary shall conduct a study on the content of training for certified nurse aides and supervisory staff of skilled nursing facilities and nursing facilities. The study shall include an analysis of the following:

(A) Whether the number of initial training hours for certified nurse aides required under sections 1819(f)(2)(A)(i)(II) and 1919(f)(2)(A)(i)(II) of the Social Security Act (42 U.S.C. 1395i–3(f)(2)(A)(i)(II); 1396r(f)(2)(A)(i)(II)) should be increased from 75 and, if so, what the required number of initial training hours should be, including any recommendations for the content of such training (including training related to dementia).

(B) Whether requirements for ongoing training under such sections 1819(f)(2)(A)(i)(II) and 1919(f)(2)(A)(i)(II)

should be increased from 12 hours per year, including any recommendations for the content of such training.

(2) CONSULTATION.—In conducting the analysis under paragraph (1)(A), the Secretary shall consult with States that, as of the date of the enactment of this Act, require more than 75 hours of training for certified nurse aides.

(3) DEFINITIONS.—In this section:

(A) NURSING FACILITY.—The term ''nursing facility'' has the meaning given such term in section 1919(a) of the Social Security Act (42 U.S.C. 1396r(a)).

(B) SECRETARY.—The term ''Secretary'' means the Secretary of Health and Human Services, acting through the Assistant Secretary for Planning and Evaluation.

(C) SKILLED NURSING FACILITY.—The term ''skilled nursing facility'' has the meaning given such term in section 1819(a) of the Social Security Act (42 U.S.C. 1395(a)).

(b) REPORT.—Not later than 2 years after the date of the enactment of this Act, the Secretary shall submit to Congress a report containing the results of the study conducted under subsection (a), together with rec-

ommendations for such legislation and administrative action as the Secretary determines appropriate.

SEC. 1433. QUALIFICATION OF DIRECTOR OF FOOD SERVICES OF A SKILLED NURSING FACILITY OR NURSING FACILITY.

(a) MEDICARE.—Section 1819(b)(4)(A) of the Social Security Act (42 U.S.C. 1395i–3(b)(4)(A)) is amended by adding at the end the following: ''With respect to meeting the staffing requirement imposed by the Secretary to carry out clause (iv), the full-time director of food services of the facility, if not a qualified dietitian (as defined in section 483.35(a)(2) of title 42, Code of Federal Regulations, as in effect as of the date of the enactment of this sentence), shall be a Certified Dietary Manager meeting the requirements of the Certifying Board for Dietary Managers, or a Dietetic Technician, Registered meeting the requirements of the Commission on Dietetic Registration or have equivalent military, academic, or other qualifications (as specified by the Secretary).''.

(b) MEDICAID.—Section 1919(b)(4)(A) of the Social Security Act (42 U.S.C. 1396r(b)(4)(A)) is amended by adding at the end the following: ''With respect to meeting the staffing requirement imposed by the Secretary to carry out clause (iv), the full-time director of food services of the facility, if not a qualified dietitian (as defined in sec-

tion 483.35(a)(2) of title 42, Code of Federal Regulations, as in effect as of the date of the enactment of this sentence), shall be a Certified Dietary Manager meeting the requirements of the Certifying Board for Dietary Managers, or a Dietetic Technician, Registered meeting the requirements of the Commission on Dietetic Registration or have equivalent military, academic, or other qualifications (as specified by the Secretary).''.

(c) EFFECTIVE DATE.—The amendments made by this section shall take effect on the date that is 180 days after the date of enactment of this Act.

Subtitle C—Quality Measurements

SEC. 1441. ESTABLISHMENT OF NATIONAL PRIORITIES FOR QUALITY IMPROVEMENT.

Title XI of the Social Security Act, as amended by section 1401(a), is further amended by adding at the end the following new part:

''PART E—QUALITY IMPROVEMENT

''ESTABLISHMENT OF NATIONAL PRIORITIES FOR PERFORMANCE IMPROVEMENT

''SEC. 1191. (a) ESTABLISHMENT OF NATIONAL PRIORITIES BY THE SECRETARY.—The Secretary shall establish and periodically update, not less frequently than triennially, national priorities for performance improvement.

''(b) RECOMMENDATIONS FOR NATIONAL PRIORITIES.—In establishing and updating national priorities under subsection (a), the Secretary shall solicit and consider recommendations from multiple outside stakeholders.

''(c) CONSIDERATIONS IN SETTING NATIONAL PRIORITIES.—With respect to such priorities, the Secretary shall ensure that priority is given to areas in the delivery of health care services in the United States that—

''(1) contribute to a large burden of disease, including those that address the health care provided to patients with prevalent, high-cost chronic diseases;

''(2) have the greatest potential to decrease morbidity and mortality in this country, including those that are designed to eliminate harm to patients;

''(3) have the greatest potential for improving the performance, affordability, and patient-centeredness of health care, including those due to variations in care;

''(4) address health disparities across groups and areas; and

''(5) have the potential for rapid improvement due to existing evidence, standards of care or other reasons.

''(d) DEFINITIONS.—In this part:

''(1) CONSENSUS-BASED ENTITY.—The term 'consensus-based entity' means an entity with a contract with the Secretary under section 1890.

''(2) QUALITY MEASURE.—The term 'quality measure' means a national consensus standard for measuring the performance and improvement of population health, or of institutional providers of services, physicians, and other health care practitioners in the delivery of health care services.

''(e) FUNDING.—

''(1) IN GENERAL.—The Secretary shall provide for the transfer, from the Federal Hospital Insurance Trust Fund under section 1817 and the Federal Supplementary Medical Insurance Trust Fund under section 1841 (in such proportion as the Secretary determines appropriate), of $2,000,000, for the activities under this section for each of the fiscal years 2010 through 2014.

''(2) AUTHORIZATION OF APPROPRIATIONS.—For purposes of carrying out the provisions of this section, in addition to funds otherwise available, out

of any funds in the Treasury not otherwise appropriated, there are appropriated to the Secretary of Health and Human Services $2,000,000 for each of the fiscal years 2010 through 2014.''.

SEC. 1442. DEVELOPMENT OF NEW QUALITY MEASURES; GAO EVALUATION OF DATA COLLECTION PROCESS FOR QUALITY MEASUREMENT.

Part E of title XI of the Social Security Act, as added by section 1441, is amended by adding at the end the following new sections:

''SEC. 1192. DEVELOPMENT OF NEW QUALITY MEASURES.

''(a) AGREEMENTS WITH QUALIFIED ENTITIES.—

''(1) IN GENERAL.—The Secretary shall enter into agreements with qualified entities to develop quality measures for the delivery of health care services in the United States.

''(2) FORM OF AGREEMENTS.—The Secretary may carry out paragraph (1) by contract, grant, or otherwise.

''(3) RECOMMENDATIONS OF CONSENSUS-BASED ENTITY.—In carrying out this section, the Secretary shall—

''(A) seek public input; and

''(B) take into consideration recommendations of the consensus-based entity with a contract with the Secretary under section 1890(a).

''(b) DETERMINATION OF AREAS WHERE QUALITY MEASURES ARE REQUIRED.—Consistent with the national priorities established under this part and with the programs administered by the Centers for Medicare & Medicaid Services and in consultation with other relevant Federal agencies, the Secretary shall determine areas in which quality measures for assessing health care services in the United States are needed.

''(c) DEVELOPMENT OF QUALITY MEASURES.—

''(1) PATIENT-CENTERED AND POPULATION-BASED MEASURES.—In entering into agreements under subsection (a), the Secretary shall give priority to the development of quality measures that allow the assessment of—

''(A) health outcomes, presence of impairment, and functional status of patients;

''(B) the continuity and coordination of care and care transitions for patients across providers and health care settings, including end of life care;

''(C) patient experience and patient engagement;

''(D) the safety, effectiveness, and timeliness of care;

''(E) health disparities including those associated with individual race, ethnicity, age, gender, place of residence or language; and

''(F) the efficiency and resource use in the provision of care.

''(2) USE OF FUNDS.—An entity that enters into an agreement under subsection (a) shall develop quality measures that—

''(A) to the extent feasible, have the ability to be collected through the use of health information technologies supporting better delivery of health care services; and

''(B) are available free of charge to users for the use of such measures.

''(3) AVAILABILITY OF MEASURES.—The Secretary shall make quality measures developed under this section available to the public.

''(4) TESTING OF PROPOSED MEASURES.—The Secretary may use amounts made available under subsection (f) to fund the testing of proposed quality measures by qualified entities. Testing funded under this paragraph shall include testing of the feasibility and usability of proposed measures.

''(5) UPDATING OF ENDORSED MEASURES.—The Secretary may use amounts made available under subsection (f) to fund the updating (and testing, if applicable) by consensus-based entities of quality measures that have been previously endorsed by such an entity as new evidence is developed, in a manner consistent with section 1890(b)(3).

''(d) QUALIFIED ENTITIES.—Before entering into agreements with a qualified entity, the Secretary shall ensure that the entity is a public, private, or academic institution with technical expertise in the area of health quality measurement.

''(e) APPLICATION FOR GRANT.—A grant may be made under this section only if an application for the grant is submitted to the Secretary and the application is in such form, is made in such manner, and contains such agreements, assurances, and information as the Secretary determines to be necessary to carry out this section.

''(f) FUNDING.—

''(1) IN GENERAL.—The Secretary shall provide for the transfer, from the Federal Hospital Insurance Trust Fund under section 1817 and the Federal Supplementary Medical Insurance Trust Fund under section 1841 (in such proportion as the Secretary determines appropriate), of $25,000,000, to

the Secretary for purposes of carrying out this section for each of the fiscal years 2010 through 2014.

''(2) AUTHORIZATION OF APPROPRIATIONS.—For purposes of carrying out the provisions of this section, in addition to funds otherwise available, out of any funds in the Treasury not otherwise appropriated, there are appropriated to the Secretary of Health and Human Services $25,000,000 for each of the fiscal years 2010 through 2014.

''SEC. 1193. GAO EVALUATION OF DATA COLLECTION PROCESS FOR QUALITY MEASUREMENT.

''(a) GAO EVALUATIONS.—The Comptroller General of the United States shall conduct periodic evaluations of the implementation of the data collection processes for quality measures used by the Secretary.

''(b) CONSIDERATIONS.—In carrying out the evaluation under subsection (a), the Comptroller General shall determine—

''(1) whether the system for the collection of data for quality measures provides for validation of data as relevant and scientifically credible;

''(2) whether data collection efforts under the system use the most efficient and cost-effective means in a manner that minimizes administrative burden on persons required to collect data and that

adequately protects the privacy of patients' personal health information and provides data security;

''(3) whether standards under the system provide for an appropriate opportunity for physicians and other clinicians and institutional providers of services to review and correct findings; and

''(4) the extent to which quality measures are consistent with section 1192(c)(1) or result in direct or indirect costs to users of such measures.

''(c) REPORT.—The Comptroller General shall submit reports to Congress and to the Secretary containing a description of the findings and conclusions of the results of each such evaluation.''.

SEC. 1443. MULTI-STAKEHOLDER PRE-RULEMAKING INPUT INTO SELECTION OF QUALITY MEASURES.

Section 1808 of the Social Security Act (42 U.S.C. 1395b–9) is amended by adding at the end the following new subsection:

''(d) MULTI-STAKEHOLDER PRE-RULEMAKING INPUT INTO SELECTION OF QUALITY MEASURES.—

''(1) LIST OF MEASURES.—Not later than December 1 before each year (beginning with 2011), the Secretary shall make public a list of measures being considered for selection for quality measurement by the Secretary in rulemaking with respect to

payment systems under this title beginning in the payment year beginning in such year and for payment systems beginning in the calendar year following such year, as the case may be.

''(2) CONSULTATION ON SELECTION OF ENDORSED QUALITY MEASURES.—A consensus-based entity that has entered into a contract under section 1890 shall, as part of such contract, convene multi-stakeholder groups to provide recommendations on the selection of individual or composite quality measures, for use in reporting performance information to the public or for use in public health care programs.

''(3) MULTI-STAKEHOLDER INPUT.—Not later than February 1 of each year (beginning with 2011), the consensus-based entity described in paragraph (2) shall transmit to the Secretary the recommendations of multi-stakeholder groups provided under paragraph (2). Such recommendations shall be included in the transmissions the consensus-based entity makes to the Secretary under the contract provided for under section 1890.

''(4) REQUIREMENT FOR TRANSPARENCY IN PROCESS.—

''(A) IN GENERAL.—In convening multi-stakeholder groups under paragraph (2) with respect to the selection of quality measures, the consensus-based entity described in such paragraph shall provide for an open and transparent process for the activities conducted pursuant to such convening.

''(B) SELECTION OF ORGANIZATIONS PARTICIPATING IN MULTI-STAKEHOLDER GROUPS.—The process under paragraph (2) shall ensure that the selection of representatives of multi-stakeholder groups includes provision for public nominations for, and the opportunity for public comment on, such selection.

''(5) USE OF INPUT.—The respective proposed rule shall contain a summary of the recommendations made by the multi-stakeholder groups under paragraph (2), as well as other comments received regarding the proposed measures, and the extent to which such proposed rule follows such recommendations and the rationale for not following such recommendations.

''(6) MULTI-STAKEHOLDER GROUPS.—For purposes of this subsection, the term 'multi-stakeholder groups' means, with respect to a quality measure, a

voluntary collaborative of organizations representing persons interested in or affected by the use of such quality measure, such as the following:

"(A) Hospitals and other institutional providers.

"(B) Physicians.

"(C) Health care quality alliances.

"(D) Nurses and other health care practitioners.

"(E) Health plans.

"(F) Patient advocates and consumer groups.

"(G) Employers.

"(H) Public and private purchasers of health care items and services.

"(I) Labor organizations.

"(J) Relevant departments or agencies of the United States.

"(K) Biopharmaceutical companies and manufacturers of medical devices.

"(L) Licensing, credentialing, and accrediting bodies.

"(7) FUNDING.—

"(A) IN GENERAL.—The Secretary shall provide for the transfer, from the Federal Hos-

pital Insurance Trust Fund under section 1817 and the Federal Supplementary Medical Insurance Trust Fund under section 1841 (in such proportion as the Secretary determines appropriate), of $1,000,000, to the Secretary for purposes of carrying out this subsection for each of the fiscal years 2010 through 2014.

''(B) AUTHORIZATION OF APPROPRIATIONS.—For purposes of carrying out the provisions of this subsection, in addition to funds otherwise available, out of any funds in the Treasury not otherwise appropriated, there are appropriated to the Secretary of Health and Human Services $1,000,000 for each of the fiscal years 2010 through 2014.''.

SEC. 1444. APPLICATION OF QUALITY MEASURES.

(a) INPATIENT HOSPITAL SERVICES.—Section 1886(b)(3)(B) of such Act (42 U.S.C. 1395ww(b)(3)(B)) is amended by adding at the end the following new clause:

''(x)(I) Subject to subclause (II), for purposes of reporting data on quality measures for inpatient hospital services furnished during fiscal year 2012 and each subsequent fiscal year, the quality measures specified under clause (viii) shall be measures selected by the Secretary

from measures that have been endorsed by the entity with a contract with the Secretary under section 1890(a).

''(II) In the case of a specified area or medical topic determined appropriate by the Secretary for which a feasible and practical quality measure has not been endorsed by the entity with a contract under section 1890(a), the Secretary may specify a measure that is not so endorsed as long as due consideration is given to measures that have been endorsed or adopted by a consensus organization identified by the Secretary. The Secretary shall submit such a non-endorsed measure to the entity for consideration for endorsement. If the entity considers but does not endorse such a measure and if the Secretary does not phase-out use of such measure, the Secretary shall include the rationale for continued use of such a measure in rulemaking.''.

(b) OUTPATIENT HOSPITAL SERVICES.—Section 1833(t)(17) of such Act (42 U.S.C. 1395l(t)(17)) is amended by adding at the end the following new subparagraph:

''(F) USE OF ENDORSED QUALITY MEASURES.—The provisions of clause (x) of section 1886(b)(3)(C) shall apply to quality measures for covered OPD services under this paragraph in the same manner as such provisions apply to

quality measures for inpatient hospital services.''.

(c) PHYSICIANS' SERVICES.—Section 1848(k)(2)(C)(ii) of such Act (42 U.S.C. 1395w-4(k)(2)(C)(ii)) is amended by adding at the end the following: ''The Secretary shall submit such a non-endorsed measure to the entity for consideration for endorsement. If the entity considers but does not endorse such a measure and if the Secretary does not phase-out use of such measure, the Secretary shall include the rationale for continued use of such a measure in rulemaking.''.

(d) RENAL DIALYSIS SERVICES.—Section 1881(h)(2)(B)(ii) of such Act (42 U.S.C. 1395rr(h)(2)(B)(ii)) is amended by adding at the end the following: ''The Secretary shall submit such a non-endorsed measure to the entity for consideration for endorsement. If the entity considers but does not endorse such a measure and if the Secretary does not phase-out use of such measure, the Secretary shall include the rationale for continued use of such a measure in rulemaking.''.

(e) ENDORSEMENT OF STANDARDS.—Section 1890(b)(2) of the Social Security Act (42 U.S.C. 1395aaa(b)(2)) is amended by adding after and below subparagraph (B) the following:

''If the entity does not endorse a measure, such entity shall explain the reasons and provide suggestions about changes to such measure that might make it a potentially endorsable measure.''.

(f) EFFECTIVE DATE.—Except as otherwise provided, the amendments made by this section shall apply to quality measures applied for payment years beginning with 2012 or fiscal year 2012, as the case may be.

SEC. 1445. CONSENSUS-BASED ENTITY FUNDING.

Section 1890(d) of the Social Security Act (42 U.S.C. 1395aaa(d)) is amended by striking ''for each of fiscal years 2009 through 2012'' and inserting ''for fiscal year 2009, and $12,000,000 for each of the fiscal years 2010 through 2012''

Subtitle D—Physician Payments Sunshine Provision

SEC. 1451. REPORTS ON FINANCIAL RELATIONSHIPS BETWEEN MANUFACTURERS AND DISTRIBUTORS OF COVERED DRUGS, DEVICES, BIOLOGICALS, OR MEDICAL SUPPLIES UNDER MEDICARE, MEDICAID, OR CHIP AND PHYSICIANS AND OTHER HEALTH CARE ENTITIES AND BETWEEN PHYSICIANS AND OTHER HEALTH CARE ENTITIES.

(a) IN GENERAL.—Part A of title XI of the Social Security Act (42 U.S.C. 1301 et seq.), as amended by section 1631(a), is further amended by inserting after section 1128G the following new section:

"SEC. 1128H. FINANCIAL REPORTS ON PHYSICIANS' FINANCIAL RELATIONSHIPS WITH MANUFACTURERS AND DISTRIBUTORS OF COVERED DRUGS, DEVICES, BIOLOGICALS, OR MEDICAL SUPPLIES UNDER MEDICARE, MEDICAID, OR CHIP AND WITH ENTITIES THAT BILL FOR SERVICES UNDER MEDICARE.

"(a) REPORTING OF PAYMENTS OR OTHER TRANSFERS OF VALUE.—

"(1) IN GENERAL.—Except as provided in this subsection, not later than March 31, 2011, and an-

nually thereafter, each applicable manufacturer or distributor that provides a payment or other transfer of value to a covered recipient, or to an entity or individual at the request of or designated on behalf of a covered recipient, shall submit to the Secretary, in such electronic form as the Secretary shall require, the following information with respect to the preceding calendar year:

''(A) With respect to the covered recipient, the recipient's name, business address, physician specialty, and national provider identifier.

''(B) With respect to the payment or other transfer of value, other than a drug sample—

''(i) its value and date;

''(ii) the name of the related drug, device, or supply, if available, to the level of specificity available; and

''(iii) a description of its form, indicated (as appropriate for all that apply) as—

''(I) cash or a cash equivalent;

''(II) in-kind items or services;

''(III) stock, a stock option, or any other ownership interest, divi-

dend, profit, or other return on investment; or

''(IV) any other form (as defined by the Secretary).

''(C) With respect to a drug sample, the name, number, date, and dosage units of the sample.

''(2) AGGREGATE REPORTING.—Information submitted by an applicable manufacturer or distributor under paragraph (1) shall include the aggregate amount of all payments or other transfers of value provided by the manufacturer or distributor to covered recipients (and to entities or individuals at the request of or designated on behalf of a covered recipient) during the year involved, including all payments and transfers of value regardless of whether such payments or transfer of value were individually disclosed.

''(3) SPECIAL RULE FOR CERTAIN PAYMENTS OR OTHER TRANSFERS OF VALUE.—In the case where an applicable manufacturer or distributor provides a payment or other transfer of value to an entity or individual at the request of or designated on behalf of a covered recipient, the manufacturer or distributor shall disclose that payment or other

transfer of value under the name of the covered recipient.

''(4) DELAYED REPORTING FOR PAYMENTS MADE PURSUANT TO PRODUCT DEVELOPMENT AGREEMENTS.—In the case of a payment or other transfer of value made to a covered recipient by an applicable manufacturer or distributor pursuant to a product development agreement for services furnished in connection with the development of a new drug, device, biological, or medical supply, the applicable manufacturer or distributor may report the value and recipient of such payment or other transfer of value in the first reporting period under this subsection in the next reporting deadline after the earlier of the following:

''(A) The date of the approval or clearance of the covered drug, device, biological, or medical supply by the Food and Drug Administration.

''(B) Two calendar years after the date such payment or other transfer of value was made.

''(5) DELAYED REPORTING FOR PAYMENTS MADE PURSUANT TO CLINICAL INVESTIGATIONS.—In the case of a payment or other transfer of value

made to a covered recipient by an applicable manufacturer or distributor in connection with a clinical investigation regarding a new drug, device, biological, or medical supply, the applicable manufacturer or distributor may report as required under this section in the next reporting period under this subsection after the earlier of the following:

''(A) The date that the clinical investigation is registered on the website maintained by the National Institutes of Health pursuant to section 671 of the Food and Drug Administration Amendments Act of 2007.

''(B) Two calendar years after the date such payment or other transfer of value was made.

''(6) CONFIDENTIALITY.—Information described in paragraph (4) or (5) shall be considered confidential and shall not be subject to disclosure under section 552 of title 5, United States Code, or any other similar Federal, State, or local law, until or after the date on which the information is made available to the public under such paragraph.

''(7) PHYSICIANS IN SELF-INSURED HEALTH PLANS.—Nothing in this subsection shall be construed to require the disclosure of a payment or

other transfer of value to a physician by a self-insured health plan.

''(b) REPORTING OF OWNERSHIP INTEREST BY PHYSICIANS.—

''(1) HOSPITALS AND OTHER ENTITIES THAT BILL MEDICARE.—Not later than March 31 of each year (beginning with 2011), each hospital or other health care entity (not including a Medicare Advantage organization) that bills the Secretary under part A or part B of title XVIII for services shall report on the ownership shares (other than ownership shares described in section 1877(c)) of each physician who, directly or indirectly, owns an interest in the entity.

''(2) ADDITIONAL PHYSICIAN OWNERSHIP.—Not later than March 31 of each year (beginning with 2011), in addition to the requirement under subsection (a)(1), any applicable manufacturer, applicable group purchasing organization, or applicable distributor shall submit to the Secretary, in such electronic form as the Secretary shall require, the following information regarding any ownership or investment interest (other than an ownership or investment interest in a publicly traded security and mutual fund, as described in section 1877(c)) held

by a physician (or an immediate family member of such physician (as defined for purposes of section 1877(a))) in the applicable manufacturer, applicable group purchasing organization or applicable distributor during the preceding year:

''(A) The dollar amount invested by each physician holding such an ownership or investment interest.

''(B) The value and terms of each such ownership or investment interest.

''(C) Any payment or other transfer of value provided to a physician holding such an ownership or investment interest (or to an entity or individual at the request of or designated on behalf of a physician holding such an ownership or investment interest), including the information described in clauses (i) through (iii) of paragraph (a)(1)(B), and information described in subsection (f)(8)(A) and (f)(8)(B).

''(D) Any other information regarding the ownership or investment interest the Secretary determines appropriate.

''(3) DEFINITIONS.—In this subsection:

''(A) PHYSICIAN.—The term 'physician' includes a physician's immediate family members (as defined for purposes of section 1877(a)).

''(B) APPLICABLE GROUP PURCHASING ORGANIZATION.—The term 'applicable group purchasing organization' means any organization or other entity (as defined by the Secretary) that purchases, arranges for, or negotiates the purchase of a covered drug, device, biological, or medical supply.

''(4) STUDY OF PRACTICE PATTERNS IN ADVANCED DIAGNOSTIC IMAGING AND RADIATION ONCOLOGY SERVICES.—The Comptroller General of the United States shall conduct a study to evaluate the extent of use of physician self-referral arrangements and the effects of such arrangements on the cost of providing advanced diagnostic imaging and radiation oncology services to Medicare beneficiaries under title XVIII. The study shall be completed and submitted to Congress not later than July 1, 2011.

''(c) PUBLIC AVAILABILITY.—

''(1) IN GENERAL.—The Secretary shall establish procedures to ensure that, not later than September 30, 2011, and on June 30 of each year beginning thereafter, the information submitted under

subsections (a) and (b), other than information regard drug samples, with respect to the preceding calendar year is made available through an Internet website that—

''(A) is searchable and is in a format that is clear and understandable;

''(B) contains information that is presented by the name of the applicable manufacturer or distributor, the name of the covered recipient, the business address of the covered recipient, the specialty (if applicable) of the covered recipient, the value of the payment or other transfer of value, the date on which the payment or other transfer of value was provided to the covered recipient, the form of the payment or other transfer of value, indicated (as appropriate) under subsection (a)(1)(B)(ii), the nature of the payment or other transfer of value, indicated (as appropriate) under subsection (a)(1)(B)(iii), and the name of the covered drug, device, biological, or medical supply, as applicable;

''(C) contains information that is able to be easily aggregated and downloaded;

''(D) contains a description of any enforcement actions taken to carry out this section, including any penalties imposed under subsection (d), during the preceding year;

''(E) contains background information on industry-physician relationships;

''(F) in the case of information submitted with respect to a payment or other transfer of value described in subsection (a)(5), lists such information separately from the other information submitted under subsection (a) and designates such separately listed information as funding for clinical research;

''(G) contains any other information the Secretary determines would be helpful to the average consumer; and

''(H) provides the covered recipient an opportunity to submit corrections to the information made available to the public with respect to the covered recipient.

''(2) ACCURACY OF REPORTING.—The accuracy of the information that is submitted under subsections (a) and (b) and made available under paragraph (1) shall be the responsibility of the reporting entity reporting under subsection (a) or (b), as ap-

plicable. The Secretary shall establish procedures to ensure that the covered recipient is provided with an opportunity to submit corrections to the applicable reporting entity with regard to information made public with respect to the covered recipient and, under such procedures, the corrections shall be transmitted to the Secretary.

''(3) SPECIAL RULE FOR DRUG SAMPLES.—Information relating to drug samples provided under subsection (a) shall not be made available to the public by the Secretary but may be made available outside the Department of Health and Human Services by the Secretary for research or legitimate business purposes pursuant to data use agreements.

''(4) SPECIAL RULE FOR NATIONAL PROVIDER IDENTIFIERS.—Information relating to national provider identifiers provided under subsection (a) shall not be made available to the public by the Secretary but may be made available outside the Department of Health and Human Services by the Secretary for research or legitimate business purposes pursuant to data use agreements.

''(d) PENALTIES FOR NONCOMPLIANCE.—

''(1) FAILURE TO REPORT.—

''(A) IN GENERAL.—Subject to subparagraph (B), except as provided in paragraph (2), any reporting entity that fails to submit information required under subsection (a) or (b), as applicable, in a timely manner in accordance with regulations promulgated to carry out such applicable subsection shall be subject to a civil money penalty of not less than $1,000, but not more than $10,000, for each payment or other transfer of value or ownership or investment interest not reported as required under such subsection. Such penalty shall be imposed and collected in the same manner as civil money penalties under subsection (a) of section 1128A are imposed and collected under that section.

''(B) LIMITATION.—The total amount of civil money penalties imposed under subparagraph (A), with respect to each annual submission of information under subsection (a) by a reporting entity, shall not exceed $150,000.

''(2) KNOWING FAILURE TO REPORT.—

''(A) IN GENERAL.—Subject to subparagraph (B), any reporting entity that knowingly fails to submit information required under subsection (a) or (b), as applicable, in a timely

manner in accordance with regulations promulgated to carry out such applicable subsection, shall be subject to a civil money penalty of not less than $10,000, but not more than $100,000, for each payment or other transfer of value or ownership or investment interest not reported as required under such subsection. Such penalty shall be imposed and collected in the same manner as civil money penalties under subsection (a) of section 1128A are imposed and collected under that section.

''(B) LIMITATION.—The total amount of civil money penalties imposed under subparagraph (A) with respect to each annual submission of information under subsection (a) or (b) by an applicable reporting entity shall not exceed $1,000,000, or, if greater, 0.1 percentage of the total annual revenues of the reporting entity.

''(3) USE OF FUNDS.—Funds collected by the Secretary as a result of the imposition of a civil money penalty under this subsection shall be used to carry out this section.

''(4) ENFORCEMENT THROUGH STATE ATTORNEYS GENERAL.—The attorney general of a State,

after providing notice to the Secretary of an intent to proceed under this paragraph in a specific case and providing the Secretary with an opportunity to bring an action under this subsection and the Secretary declining such opportunity, may proceed under this subsection against an applicable manufacturer or distributor in the State.

''(e) ANNUAL REPORT TO CONGRESS.—Not later than April 1 of each year beginning with 2011, the Secretary shall submit to Congress a report that includes the following:

''(1) The information submitted under this section during the preceding year, aggregated for each applicable reporting entity that submitted such information during such year.

''(2) A description of any enforcement actions taken to carry out this section, including any penalties imposed under subsection (d), during the preceding year.

''(f) DEFINITIONS.—In this section:

''(1) APPLICABLE DISTRIBUTOR.—The term 'applicable distributor' means—

''(A) any entity, other than an applicable group purchasing organization, that buys and resells, or receives a commission or other simi-

lar form of payment, from another seller, for selling or arranging for the sale of a covered drug, device, biological, or medical supply; or

''(B) any entity under common ownership with such an entity described in subparagraph (A) and which provides assistance or support to such entity so described with respect to the production, preparation, propagation, compounding, conversion, processing, marketing, or distribution of a covered drug, device, biological, or medical supply.

Such term does not include a wholesale pharmaceutical distributor.

''(2) APPLICABLE MANUFACTURER.—The term 'applicable manufacturer' means any entity which is engaged in the production, preparation, propagation, compounding, conversion, processing, marketing, or manufacturer-direct distribution of a covered drug, device, biological, or medical supply (or any entity under common ownership with such entity and which provides assistance or support to such entity with respect to the production, preparation, propagation, compounding, conversion, processing, marketing, or distribution or a covered drug, device, biological, or medical supply). For purposes of this section only,

such term does not include a retail pharmacy licensed under State law.

''(3) CLINICAL INVESTIGATION.—The term 'clinical investigation' means any experiment involving one or more human subjects, or materials derived from human subjects, in which a drug or device is administered, dispensed, or used.

''(4) COVERED DRUG, DEVICE, BIOLOGICAL, OR MEDICAL SUPPLY.—The term 'covered' means, with respect to a drug, device, biological, or medical supply, such a drug, device, biological, or medical supply for which payment is available under title XVIII or a State plan under title XIX or XXI (or a waiver of such a plan).

''(5) COVERED RECIPIENT.—The term 'covered recipient' means the following:

''(A) A physician.

''(B) A physician group practice.

''(C) Any other prescriber of a covered drug, device, biological, or medical supply.

''(D) A pharmacy or pharmacist.

''(E) A health insurance issuer, group health plan, or other entity offering a health benefits plan, including any employee of such an issuer, plan, or entity.

''(F) A pharmacy benefit manager, including any employee of such a manager.

''(G) A hospital.

''(H) A medical school.

''(I) A sponsor of a continuing medical education program.

''(J) A patient advocacy or disease specific group.

''(K) A organization of health care professionals.

''(L) A biomedical researcher.

''(M) A group purchasing organization.

''(6) EMPLOYEE.—The term 'employee' has the meaning given such term in section 1877(h)(2).

''(7) KNOWINGLY.—The term 'knowingly' has the meaning given such term in section 3729(b) of title 31, United States Code.

''(8) PAYMENT OR OTHER TRANSFER OF VALUE.—

''(A) IN GENERAL.—The term 'payment or other transfer of value' means a transfer of anything of value for or of any of the following:

''(i) Gift, food, or entertainment.

''(ii) Travel or trip.

''(iii) Honoraria.

''(iv) Research funding or grant.

''(v) Education or conference funding.

''(vi) Consulting fees.

''(vii) Ownership or investment interest and royalties or license fee.

''(B) INCLUSIONS.—Subject to subparagraph (C), the term 'payment or other transfer of value' includes any compensation, gift, honorarium, speaking fee, consulting fee, travel, services, dividend, profit distribution, stock or stock option grant, or any ownership or investment interest held by a physician in a manufacturer (excluding a dividend or other profit distribution from, or ownership or investment interest in, a publicly traded security or mutual fund (as described in section 1877(c))).

''(C) EXCLUSIONS.—The term 'payment or other transfer of value' does not include the following:

''(i) Any payment or other transfer of value provided by an applicable manufacturer or distributor to a covered recipient where the amount transferred to, requested by, or designated on behalf of the covered recipient does not exceed $5.

''(ii) The loan of a covered device for a short-term trial period, not to exceed 90 days, to permit evaluation of the covered device by the covered recipient.

''(iii) Items or services provided under a contractual warranty, including the replacement of a covered device, where the terms of the warranty are set forth in the purchase or lease agreement for the covered device.

''(iv) A transfer of anything of value to a covered recipient when the covered recipient is a patient and not acting in the professional capacity of a covered recipient.

''(v) In-kind items used for the provision of charity care.

''(vi) A dividend or other profit distribution from, or ownership or investment interest in, a publicly traded security and mutual fund (as described in section 1877(c)).

''(vii) Compensation paid by an applicable manufacturer or distributor to a covered recipient who is directly employed by

and works solely for such manufacturer or distributor.

''(viii) Payments made to a covered recipient by an applicable manufacturer or by a health plan affiliated with an applicable manufacturer for medical care provided to employees of such manufacturer or their dependents.

''(ix) Any discount (including a rebate).

''(x) Any payment or other transfer of value that is made to a covered recipient indirectly through an entity other than the applicable manufacturer in connection with an activity or service—

''(I) in which the applicable manufacturer is unaware of the identity of the covered recipient and is not using such activity or service to market its product to the covered recipient; and

''(II) that is not designed to market or promote the product to the covered recipient.

''(xi) In the case of an applicable manufacturer who offers a self-insured

plan, payments for the provision of health care to employees under the plan.

''(9) PHYSICIAN.—The term 'physician' has the meaning given that term in section 1861(r). For purposes of this section, such term does not include a physician who is an employee of the applicable manufacturer that is required to submit information under subsection (a).

''(10) REPORTING ENTITY.—The term 'reporting entity' means—

''(A) with respect to the reporting requirement under subsection (a), an applicable manufacturer or distributor of a covered drug, device, biological, or medical supply required to report under such subsection; and

''(B) with respect to the reporting requirement under subsection (b), a hospital, other health care entity, applicable manufacturer, applicable distributor, or applicable group purchasing organization required to report physician ownership under such subsection.

''(g) ANNUAL REPORTS TO STATES.—Not later than April 1 of each year beginning with 2011, the Secretary shall submit to States a report that includes a summary of the information submitted under subsections (a), (b),

and (e) during the preceding year with respect to covered recipients or other hospitals and entities in the State.

''(h) RELATION TO STATE LAWS.—

''(1) IN GENERAL.—Effective on January 1, 2011, subject to paragraph (2), the provisions of this section shall preempt any law or regulation of a State or of a political subdivision of a State that requires an applicable manufacturer and applicable distributor (as such terms are defined in subsection (f)) to disclose or report, in any format, the type of information (described in subsection (a)) regarding a payment or other transfer of value provided by the manufacturer to a covered recipient (as so defined).

''(2) NO PREEMPTION OF ADDITIONAL REQUIREMENTS.—Paragraph (1) shall not preempt any statute or regulation of a State or political subdivision of a State that requires any of the following:

''(A) The disclosure or reporting of information not of the type required to be disclosed or reported under this section.

''(B) The disclosure or reporting, in any format, of information described in subsection (f)(8)(C), except in the case of information described in clause (i) of subsection (f)(8)(C).

''(C) The disclosure or reporting, in any format, of the type of information by any person or entity other than an applicable manufacturer (as so defined) or a covered recipient (as defined in subsection (f)).

''(D) The disclosure or reporting, in any format, of the type of information required to be disclosed or reported under this section to a Federal, State, or local governmental agency for public health surveillance, investigation, or other public health purposes or health oversight purposes.

Nothing in paragraph (1) shall be construed to limit the discovery or admissibility of information described in this paragraph in a criminal, civil, or administrative proceeding.''.

(b) AVAILABILITY OF INFORMATION FROM THE DISCLOSURE OF FINANCIAL RELATIONSHIP REPORT (DFRR).—The Secretary of Health and Human Services shall submit to Congress a report on the full results of the Disclosure of Physician Financial Relationships surveys required pursuant to section 5006 of the Deficit Reduction Act of 2005. Such report shall be submitted to Congress not later than the date that is 6 months after the date such surveys are collected and shall be made pub-

licly available on an Internet website of the Department of Health and Human Services.

(c) GAO REPORT.—Not later than December 31, 2012, the Comptroller General of the United States shall submit to Congress a report on section 1128H of the Social Security Act, as added by subsection (a). Such report shall address the extent to which important transfers of value are being adequately reported under such section (including unreported transfers required by such section as well as transfers not required to be reported by such section), the impact on States of the federal preemption provision under subsection (h) of such section, whether changes have occurred in the pattern of payments as a result of efforts to evade reporting requirements, a description of the financial relationships subject to delayed reporting under subsection (a) of such section, and any recommended improvements to the collection or the analysis of data reported under such section.

Subtitle E—Public Reporting on Health Care-Associated Infections

SEC. 1461. REQUIREMENT FOR PUBLIC REPORTING BY HOSPITALS AND AMBULATORY SURGICAL CENTERS ON HEALTH CARE-ASSOCIATED INFECTIONS.

(a) IN GENERAL.—Title XI of the Social Security Act is amended by inserting after section 1138 the following section:

"SEC. 1138A. REQUIREMENT FOR PUBLIC REPORTING BY HOSPITALS AND AMBULATORY SURGICAL CENTERS ON HEALTH CARE-ASSOCIATED INFECTIONS.

''(a) REPORTING REQUIREMENT.—

''(1) IN GENERAL.—The Secretary shall provide that a hospital (as defined in subsection (g)) or ambulatory surgical center meeting the requirements of titles XVIII or XIX may participate in the programs established under such titles only if, in accordance with this section, the hospital or center reports such information on health care-associated infections that develop in the hospital or center (and such demographic information associated with such infections) as the Secretary specifies.

''(2) REPORTING PROTOCOLS.— Such information shall be reported in accordance with reporting protocols established by the Secretary through the Director of the Centers for Disease Control and Prevention (in this section referred to as the 'CDC') and to the National Healthcare Safety Network of the CDC or under such another reporting system of such Centers as determined appropriate by the Secretary in consultation with such Director.

''(3) COORDINATION WITH HIT.—The Secretary, through the Director of the CDC and the Office of the National Coordinator for Health Information Technology, shall ensure that the transmission of information under this subsection is coordinated with systems established under the HITECH Act, where appropriate.

''(4) PROCEDURES TO ENSURE THE VALIDITY OF INFORMATION.—The Secretary shall establish procedures regarding the validity of the information submitted under this subsection in order to ensure that such information is appropriately compared across hospitals and centers. Such procedures shall address failures to report as well as errors in reporting.

''(5) IMPLEMENTATION.—Not later than 1 year after the date of enactment of this section, the Secretary, through the Director of CDC, shall promulgate regulations to carry out this section.

''(b) PUBLIC POSTING OF INFORMATION.—The Secretary shall promptly post, on the official public Internet site of the Department of Health and Human Services, the information reported under subsection (a). Such information shall be set forth in a manner that allows for the comparison of information on health care-associated infections—

''(1) among hospitals and ambulatory surgical centers; and

''(2) by demographic information.

''(c) ANNUAL REPORT TO CONGRESS.—On an annual basis the Secretary shall submit to the Congress a report that summarizes each of the following:

''(1) The number and types of health care-associated infections reported under subsection (a) in hospitals and ambulatory surgical centers during such year.

''(2) Factors that contribute to the occurrence of such infections, including health care worker immunization rates.

''(3) Based on the most recent information available to the Secretary on the composition of the professional staff of hospitals and ambulatory surgical centers, the number of certified infection control professionals on the staff of hospitals and ambulatory surgical centers.

''(4) The total increases or decreases in health care costs that resulted from increases or decreases in the rates of occurrence of each such type of infection during such year.

''(5) Recommendations, in coordination with the Center for Quality Improvement established under section 931 of the Public Health Service Act, for best practices to eliminate the rates of occurrence of each such type of infection in hospitals and ambulatory surgical centers.

''(d) NON-PREEMPTION OF STATE LAWS.—Nothing in this section shall be construed as preempting or otherwise affecting any provision of State law relating to the disclosure of information on health care-associated infections or patient safety procedures for a hospital or ambulatory surgical center.

''(e) HEALTH CARE-ASSOCIATED INFECTION.—For purposes of this section:

''(1) IN GENERAL.—The term 'health care-associated infection' means an infection that develops in a patient who has received care in any institutional setting where health care is delivered and is related to receiving health care.

''(2) RELATED TO RECEIVING HEALTH CARE.—The term 'related to receiving health care', with respect to an infection, means that the infection was not incubating or present at the time health care was provided.

''(f) APPLICATION TO CRITICAL ACCESS HOSPITALS.—For purposes of this section, the term 'hospital' includes a critical access hospital, as defined in section 1861(mm)(1).''.

(b) EFFECTIVE DATE.—With respect to section 1138A of the Social Security Act (as inserted by subsection (a) of this section), the requirement under such section that hospitals and ambulatory surgical centers submit reports takes effect on such date (not later than 2 years after the date of the enactment of this Act) as the Secretary of Health and Human Services shall specify. In order to meet such deadline, the Secretary may implement such section through guidance or other instructions.

(c) GAO REPORT.—Not later than 18 months after the date of the enactment of this Act, the Comptroller

General of the United States shall submit to Congress a report on the program established under section 1138A of the Social Security Act, as inserted by subsection (a). Such report shall include an analysis of the appropriateness of the types of information required for submission, compliance with reporting requirements, the success of the validity procedures established, and any conflict or overlap between the reporting required under such section and any other reporting systems mandated by either the States or the Federal Government.

(d) REPORT ON ADDITIONAL DATA.—Not later than 18 months after the date of the enactment of this Act, the Secretary of Health and Human Services shall submit to the Congress a report on the appropriateness of expanding the requirements under such section to include additional information (such as health care worker immunization rates), in order to improve health care quality and patient safety.

TITLE V—MEDICARE GRADUATE MEDICAL EDUCATION

SEC. 1501. DISTRIBUTION OF UNUSED RESIDENCY POSITIONS.

(a) IN GENERAL.—Section 1886(h) of the Social Security Act (42 U.S.C. 1395ww(h)) is amended—

(1) in paragraph (4)(F)(i), by striking ''paragraph (7)'' and inserting ''paragraphs (7) and (8)'';

(2) in paragraph (4)(H)(i), by striking ''paragraph (7)'' and inserting ''paragraphs (7) and (8)'';

(3) in paragraph (7)(E), by inserting ''and paragraph (8)'' after ''this paragraph''; and

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

''(8) ADDITIONAL REDISTRIBUTION OF UNUSED RESIDENCY POSITIONS.—

''(A) REDUCTIONS IN LIMIT BASED ON UNUSED POSITIONS.—

''(i) PROGRAMS SUBJECT TO REDUCTION.—If a hospital's reference resident level (specified in clause (ii)) is less than the otherwise applicable resident limit (as defined in subparagraph (C)(ii)), effective for portions of cost reporting periods occurring on or after July 1, 2011, the otherwise applicable resident limit shall be reduced by 90 percent of the difference between such otherwise applicable resident limit and such reference resident level.

''(ii) REFERENCE RESIDENT LEVEL.—

''(I) IN GENERAL.—Except as otherwise provided in a subsequent subclause, the reference resident level specified in this clause for a hospital is the highest resident level for any of the 3 most recent cost reporting periods (ending before the date of the enactment of this paragraph) of the hospital for which a cost report has been settled (or, if not, submitted (subject to audit)), as determined by the Secretary.

''(II) USE OF MOST RECENT ACCOUNTING PERIOD TO RECOGNIZE EXPANSION OF EXISTING PROGRAMS.—If a hospital submits a timely request to increase its resident level due to an expansion, or planned expansion, of an existing residency training program that is not reflected on the most recent settled or submitted cost report, after audit and subject to the discretion of the Secretary, subject to subclause (IV), the reference resident level for such hospital is the resident

level that includes the additional residents attributable to such expansion or establishment, as determined by the Secretary. The Secretary is authorized to determine an alternative reference resident level for a hospital that submitted to the Secretary a timely request, before the start of the 2009–2010 academic year, for an increase in its reference resident level due to a planned expansion.

''(III) SPECIAL PROVIDER AGREEMENT.—In the case of a hospital described in paragraph (4)(H)(v), the reference resident level specified in this clause is the limitation applicable under subclause (I) of such paragraph.

''(IV) PREVIOUS REDISTRIBUTION.—The reference resident level specified in this clause for a hospital shall be increased to the extent required to take into account an increase in resident positions made available to the hospital under para-

graph (7)(B) that are not otherwise taken into account under a previous subclause.

''(iii) AFFILIATION.—The provisions of clause (i) shall be applied to hospitals which are members of the same affiliated group (as defined by the Secretary under paragraph (4)(H)(ii)) and to the extent the hospitals can demonstrate that they are filling any additional resident slots allocated to other hospitals through an affiliation agreement, the Secretary shall adjust the determination of available slots accordingly, or which the Secretary otherwise has permitted the resident positions (under section 402 of the Social Security Amendments of 1967) to be aggregated for purposes of applying the resident position limitations under this subsection.

''(B) REDISTRIBUTION.—

''(i) IN GENERAL.—The Secretary shall increase the otherwise applicable resident limit for each qualifying hospital that submits an application under this subparagraph by such number as the Secretary

may approve for portions of cost reporting periods occurring on or after July 1, 2011. The estimated aggregate number of increases in the otherwise applicable resident limit under this subparagraph may not exceed the Secretary's estimate of the aggregate reduction in such limits attributable to subparagraph (A).

''(ii) REQUIREMENTS FOR QUALIFYING HOSPITALS.—A hospital is not a qualifying hospital for purposes of this paragraph unless the following requirements are met:

''(I) MAINTENANCE OF PRIMARY CARE RESIDENT LEVEL.—The hospital maintains the number of primary care residents at a level that is not less than the base level of primary care residents increased by the number of additional primary care resident positions provided to the hospital under this subparagraph. For purposes of this subparagraph, the 'base level of primary care residents' for a hospital is the level of such residents

as of a base period (specified by the Secretary), determined without regard to whether such positions were in excess of the otherwise applicable resident limit for such period but taking into account the application of subclauses (II) and (III) of subparagraph (A)(ii).

''(II) DEDICATED ASSIGNMENT OF ADDITIONAL RESIDENT POSITIONS TO PRIMARY CARE.—The hospital assigns all such additional resident positions for primary care residents.

''(III) ACCREDITATION.—The hospital's residency programs in primary care are fully accredited or, in the case of a residency training program not in operation as of the base year, the hospital is actively applying for such accreditation for the program for such additional resident positions (as determined by the Secretary).

''(iii) CONSIDERATIONS IN REDISTRIBUTION.—In determining for which qualifying hospitals the increase in the oth-

erwise applicable resident limit is provided under this subparagraph, the Secretary shall take into account the demonstrated likelihood of the hospital filling the positions within the first 3 cost reporting periods beginning on or after July 1, 2011, made available under this subparagraph, as determined by the Secretary.

''(iv) PRIORITY FOR CERTAIN HOSPITALS.—In determining for which qualifying hospitals the increase in the otherwise applicable resident limit is provided under this subparagraph, the Secretary shall distribute the increase to qualifying hospitals based on the following criteria:

''(I) The Secretary shall give preference to hospitals that had a reduction in resident training positions under subparagraph (A).

''(II) The Secretary shall give preference to hospitals with 3-year primary care residency training programs, such as family practice and general internal medicine.

''(III) The Secretary shall give preference to hospitals insofar as they have in effect formal arrangements (as determined by the Secretary) that place greater emphasis upon training in Federally qualified health centers, rural health clinics, and other nonprovider settings, and to hospitals that receive additional payments under subsection (d)(5)(F) and emphasize training in an outpatient department.

''(IV) The Secretary shall give preference to hospitals with a number of positions (as of July 1, 2009) in excess of the otherwise applicable resident limit for such period.

''(V) The Secretary shall give preference to hospitals that place greater emphasis upon training in a health professional shortage area (designated under section 332 of the Public Health Service Act) or a health professional needs area (designated under section 2211 of such Act).

''(VI) The Secretary shall give preference to hospitals in States that have low resident-to-population ratios (including a greater preference for those States with lower resident-to-population ratios).

''(v) LIMITATION.—In no case shall more than 20 full-time equivalent additional residency positions be made available under this subparagraph with respect to any hospital.

''(vi) APPLICATION OF PER RESIDENT AMOUNTS FOR PRIMARY CARE.—With respect to additional residency positions in a hospital attributable to the increase provided under this subparagraph, the approved FTE resident amounts are deemed to be equal to the hospital per resident amounts for primary care and nonprimary care computed under paragraph (2)(D) for that hospital.

''(vii) DISTRIBUTION.—The Secretary shall distribute the increase in resident training positions to qualifying hospitals

under this subparagraph not later than July 1, 2011.

''(C) RESIDENT LEVEL AND LIMIT DEFINED.—In this paragraph:

''(i) The term 'resident level' has the meaning given such term in paragraph (7)(C)(i).

''(ii) The term 'otherwise applicable resident limit' means, with respect to a hospital, the limit otherwise applicable under subparagraphs (F)(i) and (H) of paragraph (4) on the resident level for the hospital determined without regard to this paragraph but taking into account paragraph (7)(A).

''(D) MAINTENANCE OF PRIMARY CARE RESIDENT LEVEL.—In carrying out this paragraph, the Secretary shall require hospitals that receive additional resident positions under subparagraph (B)—

''(i) to maintain records, and periodically report to the Secretary, on the number of primary care residents in its residency training programs; and

''(ii) as a condition of payment for a cost reporting period under this subsection for such positions, to maintain the level of such positions at not less than the sum of—

''(I) the base level of primary care resident positions (as determined under subparagraph (B)(ii)(I)) before receiving such additional positions; and

''(II) the number of such additional positions.''.

(b) IME.—

(1) IN GENERAL.—Section 1886(d)(5)(B)(v) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(B)(v)), in the third sentence, is amended—

(A) by striking ''subsection (h)(7)'' and inserting ''subsections (h)(7) and (h)(8)''; and

(B) by striking ''it applies'' and inserting ''they apply''.

(2) CONFORMING PROVISION.—Section 1886(d)(5)(B) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(B)) is amended by adding at the end the following clause:

''(x) For discharges occurring on or after July 1, 2011, insofar as an additional payment amount under this subparagraph is attributable to resident positions distributed to a hospital under subsection (h)(8)(B), the indirect teaching adjustment factor shall be computed in the same manner as provided under clause (ii) with respect to such resident positions.''.

(c) CONFORMING AMENDMENT.—Section 422(b)(2) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173) is amended by striking ''section 1886(h)(7)'' and all that follows and inserting ''paragraphs (7) and (8) of subsection (h) of section 1886 of the Social Security Act.''.

SEC. 1502. INCREASING TRAINING IN NONPROVIDER SETTINGS.

(a) DIRECT GME.—Section 1886(h)(4)(E) of the Social Security Act (42 U.S.C. 1395ww(h)) is amended—

(1) by designating the first sentence as a clause (i) with the heading ''IN GENERAL.—'' and appropriate indentation;

(2) by striking ''shall be counted and that all the time'' and inserting ''shall be counted and that—

''(I) effective for cost reporting periods beginning before July 1, 2009, all the time'';

(3) in subclause (I), as inserted by paragraph (1), by striking the period at the end and inserting ''; and''; and

(A) by inserting after subclause (I), as so inserted, the following:

''(II) effective for cost reporting periods beginning on or after July 1, 2009, all the time so spent by a resident shall be counted towards the determination of full-time equivalency, without regard to the setting in which the activities are performed, if the hospital incurs the costs of the stipends and fringe benefits of the resident during the time the resident spends in that setting.

Any hospital claiming under this subparagraph for time spent in a nonprovider setting shall maintain and make available to the Secretary records regarding the amount of such time and such amount in comparison with amounts of such time in

such base year as the Secretary shall specify.''.

(b) IME.—Section 1886(d)(5)(B)(iv) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(B)(iv)) is amended—

(1) by striking ''(iv) Effective for discharges occurring on or after October 1, 1997'' and inserting ''(iv)(I) Effective for discharges occurring on or after October 1, 1997, and before July 1, 2009''; and

(2) by inserting after subclause (I), as inserted by paragraph (1), the following new subclause:

''(II) Effective for discharges occurring on or after July 1, 2009, all the time spent by an intern or resident in patient care activities at an entity in a nonprovider setting shall be counted towards the determination of full-time equivalency if the hospital incurs the costs of the stipends and fringe benefits of the intern or resident during the time the intern or resident spends in that setting.''.

(c) OIG STUDY ON IMPACT ON TRAINING.—The Inspector General of the Department of Health and Human Services shall analyze the data collected by the Secretary of Health and Human Services from the records made available to the Secretary under section 1886(h)(4)(E) of

the Social Security Act, as amended by subsection (a), in order to assess the extent to which there is an increase in time spent by medical residents in training in nonprovider settings as a result of the amendments made by this section. Not later than 4 years after the date of the enactment of this Act, the Inspector General shall submit a report to Congress on such analysis and assessment.

(d) DEMONSTRATION PROJECT FOR APPROVED TEACHING HEALTH CENTERS.—

(1) IN GENERAL.—The Secretary of Health and Human Services shall conduct a demonstration project under which an approved teaching health center (as defined in paragraph (3)) would be eligible for payment under subsections (h) and (k) of section 1886 of the Social Security Act (42 U.S.C. 1395ww) of amounts for its own direct costs of graduate medical education activities for primary care residents, as well as for the direct costs of graduate medical education activities of its contracting hospital for such residents, in a manner similar to the manner in which such payments would be made to a hospital if the hospital were to operate such a program.

(2) CONDITIONS.—Under the demonstration project—

(A) an approved teaching health center shall contract with an accredited teaching hospital to carry out the inpatient responsibilities of the primary care residency program of the hospital involved and is responsible for payment to the hospital for the hospital's costs of the salary and fringe benefits for residents in the program;

(B) the number of primary care residents of the center shall not count against the contracting hospital's resident limit; and

(C) the contracting hospital shall agree not to diminish the number of residents in its primary care residency training program.

(3) APPROVED TEACHING HEALTH CENTER DEFINED.—In this subsection, the term ''approved teaching health center'' means a nonprovider setting, such as a Federally qualified health center or rural health clinic (as defined in section 1861(aa) of the Social Security Act), that develops and operates an accredited primary care residency program for which funding would be available if it were operated by a hospital.

SEC. 1503. RULES FOR COUNTING RESIDENT TIME FOR DIDACTIC AND SCHOLARLY ACTIVITIES AND OTHER ACTIVITIES.

(a) DIRECT GME.—Section 1886(h) of the Social Security Act (42 U.S.C. 1395ww(h)) is amended—

(1) in paragraph (4)(E), as amended by section 1502(a)—

(A) in clause (i), by striking ''Such rules'' and inserting ''Subject to clause (ii), such rules''; and

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

''(ii) TREATMENT OF CERTAIN NONPROVIDER AND DIDACTIC ACTIVITIES.—Such rules shall provide that all time spent by an intern or resident in an approved medical residency training program in a nonprovider setting that is primarily engaged in furnishing patient care (as defined in paragraph (5)(K)) in nonpatient care activities, such as didactic conferences and seminars, but not including research not associated with the treatment or diagnosis of a particular patient, as such time and activities are defined by the Secretary,

shall be counted toward the determination of full-time equivalency.'';

(2) in paragraph (4), by adding at the end the following new subparagraph:

''(I) TREATMENT OF CERTAIN TIME IN APPROVED MEDICAL RESIDENCY TRAINING PROGRAMING.—In determining the hospital's number of full-time equivalent residents for purposes of this subsection, all the time that is spent by an intern or resident in an approved medical residency training program on vacation, sick leave, or other approved leave, as such time is defined by the Secretary, and that does not prolong the total time the resident is participating in the approved program beyond the normal duration of the program shall be counted toward the determination of full-time equivalency.''; and

(3) in paragraph (5), by adding at the end the following new subparagraph:

''(K) NONPROVIDER SETTING THAT IS PRIMARILY ENGAGED IN FURNISHING PATIENT CARE.—The term 'nonprovider setting that is primarily engaged in furnishing patient care' means a nonprovider setting in which the pri-

mary activity is the care and treatment of patients, as defined by the Secretary.''.

(b) IME DETERMINATIONS.—Section 1886(d)(5)(B) of such Act (42 U.S.C. 1395ww(d)(5)(B)), as amended by section 1501(b), is amended by adding at the end the following new clause:

''(xi)(I) The provisions of subparagraph (I) of subsection (h)(4) shall apply under this subparagraph in the same manner as they apply under such subsection.

''(II) In determining the hospital's number of full-time equivalent residents for purposes of this subparagraph, all the time spent by an intern or resident in an approved medical residency training program in non-patient care activities, such as didactic conferences and seminars, as such time and activities are defined by the Secretary, that occurs in the hospital shall be counted toward the determination of full-time equivalency if the hospital—

''(aa) is recognized as a subsection (d) hospital;

''(bb) is recognized as a subsection (d) Puerto Rico hospital;

''(cc) is reimbursed under a reimbursement system authorized under section 1814(b)(3); or

''(dd) is a provider-based hospital outpatient department.

''(III) In determining the hospital's number of full-time equivalent residents for purposes of this subparagraph, all the time spent by an intern or resident in an approved medical residency training program in research activities that are not associated with the treatment or diagnosis of a particular patient, as such time and activities are defined by the Secretary, shall not be counted toward the determination of full-time equivalency.''.

(c) EFFECTIVE DATES; APPLICATION.—

(1) IN GENERAL.—Except as otherwise provided, the Secretary of Health and Human Services shall implement the amendments made by this section in a manner so as to apply to cost reporting periods beginning on or after January 1, 1983.

(2) DIRECT GME.—Section 1886(h)(4)(E)(ii) of the Social Security Act, as added by subsection (a)(1)(B), shall apply to cost reporting periods beginning on or after July 1, 2008.

(3) IME.—Section 1886(d)(5)(B)(x)(III) of the Social Security Act, as added by subsection (b), shall apply to cost reporting periods beginning on or after October 1, 2001. Such section, as so added, shall not give rise to any inference on how the law in effect prior to such date should be interpreted.

(4) APPLICATION.—The amendments made by this section shall not be applied in a manner that requires reopening of any settled hospital cost reports as to which there is not a jurisdictionally proper appeal pending as of the date of the enactment of this Act on the issue of payment for indirect costs of medical education under section 1886(d)(5)(B) of the Social Security Act or for direct graduate medical education costs under section 1886(h) of such Act.

SEC. 1504. PRESERVATION OF RESIDENT CAP POSITIONS FROM CLOSED HOSPITALS.

(a) DIRECT GME.—Section 1886(h)(4)(H) of the Social Security Act (42 U.S.C. Section 1395ww(h)(4)(H)) is amended by adding at the end the following new clause:

''(vi) REDISTRIBUTION OF RESIDENCY SLOTS AFTER A HOSPITAL CLOSES.—

''(I) IN GENERAL.—The Secretary shall, by regulation, establish a process consistent with subclauses (II) and (III) under which, in the case where a hospital (other than a hospital described in clause (v)) with an approved medical residency program in a State closes on or after the date

that is 2 years before the date of the enactment of this clause, the Secretary shall increase the otherwise applicable resident limit under this paragraph for other hospitals in the State in accordance with this clause.

''(II) PROCESS FOR HOSPITALS IN CERTAIN AREAS.—In determining for which hospitals the increase in the otherwise applicable resident limit described in subclause (I) is provided, the Secretary shall establish a process to provide for such increase to one or more hospitals located in the State. Such process shall take into consideration the recommendations submitted to the Secretary by the senior health official (as designated by the chief executive officer of such State) if such recommendations are submitted not later than 180 days after the date of the hospital closure involved (or, in the case of a hospital that closed after the date that is 2 years before the date of the enactment of this clause,

180 days after such date of enactment).

''(III) LIMITATION.—The estimated aggregate number of increases in the otherwise applicable resident limits for hospitals under this clause shall be equal to the estimated number of resident positions in the approved medical residency programs that closed on or after the date described in subclause (I).''.

(b) NO EFFECT ON TEMPORARY FTE CAP ADJUSTMENTS.—The amendments made by this section shall not effect any temporary adjustment to a hospital's FTE cap under section 413.79(h) of title 42, Code of Federal Regulations (as in effect on the date of enactment of this Act) and shall not affect the application of section 1886(h)(4)(H)(v) of the Social Security Act.

(c) CONFORMING AMENDMENTS.—

(1) Section 422(b)(2) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173), as amended by section 1501(c), is amended by striking ''(7) and'' and inserting ''(4)(H)(vi), (7), and''.

(2) Section 1886(h)(7)(E) of the Social Security Act (42 U.S.C. 1395ww(h)(7)(E)) is amended by inserting ''or under paragraph (4)(H)(vi)'' after ''under this paragraph''.

SEC. 1505. IMPROVING ACCOUNTABILITY FOR APPROVED MEDICAL RESIDENCY TRAINING.

(a) SPECIFICATION OF GOALS FOR APPROVED MEDICAL RESIDENCY TRAINING PROGRAMS.—Section 1886(h)(1) of the Social Security Act (42 U.S.C. 1395ww(h)(1)) is amended—

(1) by designating the matter beginning with ''Notwithstanding'' as a subparagraph (A) with the heading ''IN GENERAL.—'' and with appropriate indentation; and

(2) by adding at the end the following new subparagraph:

''(B) GOALS AND ACCOUNTABILITY FOR APPROVED MEDICAL RESIDENCY TRAINING PROGRAMS.—The goals of medical residency training programs are to foster a physician workforce so that physicians are trained to be able to do the following:

''(i) Work effectively in various health care delivery settings, such as nonprovider settings.

''(ii) Coordinate patient care within and across settings relevant to their specialties.

''(iii) Understand the relevant cost and value of various diagnostic and treatment options.

''(iv) Work in inter-professional teams and multi-disciplinary team-based models in provider and nonprovider settings to enhance safety and improve quality of patient care.

''(v) Be knowledgeable in methods of identifying systematic errors in health care delivery and in implementing systematic solutions in case of such errors, including experience and participation in continuous quality improvement projects to improve health outcomes of the population the physicians serve.

''(vi) Be meaningful EHR users (as determined under section 1848(o)(2)) in the delivery of care and in improving the quality of the health of the community and the individuals that the hospital serves.''

(b) GAO STUDY ON EVALUATION OF TRAINING PROGRAMS.—

(1) IN GENERAL.—The Comptroller General of the United States shall conduct a study to evaluate the extent to which medical residency training programs—

(A) are meeting the goals described in section 1886(h)(1)(B) of the Social Security Act, as added by subsection (a), in a range of residency programs, including primary care and other specialties; and

(B) have the appropriate faculty expertise to teach the topics required to achieve such goals.

(2) REPORT.—Not later than 18 months after the date of the enactment of this Act, the Comptroller General shall submit to Congress a report on such study and shall include in such report recommendations as to how medical residency training programs could be further encouraged to meet such goals through means such as—

(A) development of curriculum requirements; and

(B) assessment of the accreditation processes of the Accreditation Council for Graduate

Medical Education and the American Osteopathic Association and effectiveness of those processes in accrediting medical residency programs that meet the goals referred to in paragraph (1)(A).

TITLE VI—PROGRAM INTEGRITY

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

SEC. 1601. INCREASED FUNDING AND FLEXIBILITY TO FIGHT FRAUD AND ABUSE.

(a) IN GENERAL.—Section 1817(k) of the Social Security Act (42 U.S.C. 1395i(k)) is amended—

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

''(7) ADDITIONAL FUNDING.—In addition to the funds otherwise appropriated to the Account from the Trust Fund under paragraphs (3) and (4) and for purposes described in paragraphs (3)(C) and (4)(A), there are hereby appropriated an additional $100,000,000 to such Account from such Trust Fund for each fiscal year beginning with 2011. The funds appropriated under this paragraph shall be allocated in the same proportion as the total funding appropriated with respect to paragraphs (3)(A) and (4)(A) was allocated with respect to fiscal year

2010, and shall be available without further appropriation until expended.''.

(2) in paragraph (4)(A)—

(A) by inserting ''for activities described in paragraph (3)(C) and'' after ''necessary''; and

(B) by inserting ''until expended'' after ''appropriation''.

(b) FLEXIBILITY IN PURSUING FRAUD AND ABUSE.—Section 1893(a) of the Social Security Act (42 U.S.C. 1395ddd(a)) is amended by inserting '', or otherwise,'' after ''entities''.

Subtitle B—Enhanced Penalties for Fraud and Abuse

SEC. 1611. ENHANCED PENALTIES FOR FALSE STATEMENTS ON PROVIDER OR SUPPLIER ENROLLMENT APPLICATIONS.

(a) IN GENERAL.—Section 1128A(a) of the Social Security Act (42 U.S.C. 1320a–7a(a)) is amended—

(1) in paragraph (1)(D), by striking all that follows ''in which the person was excluded'' and inserting ''under Federal law from the Federal health care program under which the claim was made, or'';

(2) by striking ''or'' at the end of paragraph (6);

(3) in paragraph (7), by inserting at the end ''or'';

(4) by inserting after paragraph (7) the following new paragraph:

''(8) knowingly makes or causes to be made any false statement, omission, or misrepresentation of a material fact in any application, agreement, bid, or contract to participate or enroll as a provider of services or supplier under a Federal health care program, including managed care organizations under title XIX, Medicare Advantage organizations under part C of title XVIII, prescription drug plan sponsors under part D of title XVIII, and entities that apply to participate as providers of services or suppliers in such managed care organizations and such plans;'';

(5) in the matter following paragraph (8), as inserted by paragraph (4), by striking ''or in cases under paragraph (7), $50,000 for each such act)'' and inserting ''in cases under paragraph (7), $50,000 for each such act, or in cases under paragraph (8), $50,000 for each false statement, omission, or misrepresentation of a material fact)''; and

(6) in the second sentence, by striking ''for a lawful purpose)'' and inserting ''for a lawful pur-

pose, or in cases under paragraph (8), an assessment of not more than 3 times the amount claimed as the result of the false statement, omission, or misrepresentation of material fact claimed by a provider of services or supplier whose application to participate contained such false statement, omission, or misrepresentation)''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to acts committed on or after January 1, 2010.

SEC. 1612. ENHANCED PENALTIES FOR SUBMISSION OF FALSE STATEMENTS MATERIAL TO A FALSE CLAIM.

(a) IN GENERAL.—Section 1128A(a) of the Social Security Act (42 U.S.C. 1320a–7a(a)), as amended by section 1611, is further amended—

(1) in paragraph (7), by striking ''or'' at the end;

(2) in paragraph (8), by inserting ''or'' at the end; and

(3) by inserting after paragraph (8), the following new paragraph:

''(9) knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim for payment for items

and services furnished under a Federal health care program;''; and

(4) in the matter following paragraph (9), as inserted by paragraph (3)—

(A) by striking ''or in cases under paragraph (8)'' and inserting ''in cases under paragraph (8)''; and

(B) by striking ''a material fact)'' and inserting ''a material fact, in cases under paragraph (9), $50,000 for each false record or statement)''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to acts committed on or after January 1, 2010.

SEC. 1613. ENHANCED PENALTIES FOR DELAYING INSPECTIONS.

(a) IN GENERAL.—Section 1128A(a) of the Social Security Act (42 U.S.C. 1320a–7a(a)), as amended by sections 1611 and 1612, is further amended—

(1) in paragraph (8), by striking ''or'' at the end;

(2) in paragraph (9), by inserting ''or'' at the end;

(3) by inserting after paragraph (9) the following new paragraph:

''(10) fails to grant timely access, upon reasonable request (as defined by the Secretary in regulations), to the Inspector General of the Department of Health and Human Services, for the purpose of audits, investigations, evaluations, or other statutory functions of the Inspector General of the Department of Health and Human Services;''; and

(4) in the matter following paragraph (10), as inserted by paragraph (3), by inserting '', or in cases under paragraph (10), $15,000 for each day of the failure described in such paragraph'' after ''false record or statement''.

(b) ENSURING TIMELY INSPECTIONS RELATING TO CONTRACTS WITH MA ORGANIZATIONS.—Section 1857(d)(2) of such Act (42 U.S.C. 1395w–27(d)(2)) is amended—

(1) in subparagraph (A), by inserting ''timely'' before ''inspect''; and

(2) in subparagraph (B), by inserting ''timely'' before ''audit and inspect''.

(c) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to violations committed on or after January 1, 2010.

SEC. 1614. ENHANCED HOSPICE PROGRAM SAFEGUARDS.

(a) MEDICARE.—Part A of title XVIII of the Social Security Act is amended by inserting after section 1819 the following new section:

"SEC. 1819A. ASSURING QUALITY OF CARE IN HOSPICE CARE.

''(a) IN GENERAL.—If the Secretary determines on the basis of a survey or otherwise, that a hospice program that is certified for participation under this title has demonstrated a substandard quality of care and failed to meet such other requirements as the Secretary may find necessary in the interest of the health and safety of the individuals who are provided care and services by the agency or organization involved and determines—

''(1) that the deficiencies involved immediately jeopardize the health and safety of the individuals to whom the program furnishes items and services, the Secretary shall take immediate action to remove the jeopardy and correct the deficiencies through the remedy specified in subsection (b)(2)(A)(iii) or terminate the certification of the program, and may provide, in addition, for 1 or more of the other remedies described in subsection (b)(2)(A); or

''(2) that the deficiencies involved do not immediately jeopardize the health and safety of the indi-

viduals to whom the program furnishes items and services, the Secretary may—

"(A) impose intermediate sanctions developed pursuant to subsection (b), in lieu of terminating the certification of the program; and

"(B) if, after such a period of intermediate sanctions, the program is still not in compliance with such requirements, the Secretary shall terminate the certification of the program.

If the Secretary determines that a hospice program that is certified for participation under this title is in compliance with such requirements but, as of a previous period, was not in compliance with such requirements, the Secretary may provide for a civil money penalty under subsection (b)(2)(A)(i) for the days in which it finds that the program was not in compliance with such requirements.

"(b) INTERMEDIATE SANCTIONS.—

"(1) DEVELOPMENT AND IMPLEMENTATION.—The Secretary shall develop and implement, by not later than July 1, 2012—

"(A) a range of intermediate sanctions to apply to hospice programs under the conditions described in subsection (a), and

''(B) appropriate procedures for appealing determinations relating to the imposition of such sanctions.

''(2) SPECIFIED SANCTIONS.—

''(A) IN GENERAL.—The intermediate sanctions developed under paragraph (1) may include—

''(i) civil money penalties in an amount not to exceed $10,000 for each day of noncompliance or, in the case of a per instance penalty applied by the Secretary, not to exceed $25,000,

''(ii) denial of all or part of the payments to which a hospice program would otherwise be entitled under this title with respect to items and services furnished by a hospice program on or after the date on which the Secretary determines that intermediate sanctions should be imposed pursuant to subsection (a)(2),

''(iii) the appointment of temporary management to oversee the operation of the hospice program and to protect and assure the health and safety of the individ-

uals under the care of the program while improvements are made,

''(iv) corrective action plans, and

''(v) in-service training for staff.

The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under clause (i) in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a). The temporary management under clause (iii) shall not be terminated until the Secretary has determined that the program has the management capability to ensure continued compliance with all requirements referred to in that clause.

''(B) CLARIFICATION.—The sanctions specified in subparagraph (A) are in addition to sanctions otherwise available under State or Federal law and shall not be construed as limiting other remedies, including any remedy available to an individual at common law.

''(C) COMMENCEMENT OF PAYMENT.—A denial of payment under subparagraph (A)(ii) shall terminate when the Secretary determines that the hospice program no longer demonstrates a substandard quality of care and

meets such other requirements as the Secretary may find necessary in the interest of the health and safety of the individuals who are provided care and services by the agency or organization involved.

''(3) SECRETARIAL AUTHORITY.—The Secretary shall develop and implement, by not later than July 1, 2011, specific procedures with respect to the conditions under which each of the intermediate sanctions developed under paragraph (1) is to be applied, including the amount of any fines and the severity of each of these sanctions. Such procedures shall be designed so as to minimize the time between identification of deficiencies and imposition of these sanctions and shall provide for the imposition of incrementally more severe fines for repeated or uncorrected deficiencies.''.

(b) APPLICATION TO MEDICAID.—Section 1905(o) of the Social Security Act (42 U.S.C. 1396d(o)) is amended by adding at the end the following new paragraph:

''(4) The provisions of section 1819A shall apply to a hospice program providing hospice care under this title in the same manner as such provisions apply to a hospice program providing hospice care under title XVIII.''.

(c) APPLICATION TO CHIP.—Title XXI of the Social Security Act is amended by adding at the end the following new section:

''SEC. 2114. ASSURING QUALITY OF CARE IN HOSPICE CARE.

''The provisions of section 1819A shall apply to a hospice program providing hospice care under this title in the same manner such provisions apply to a hospice program providing hospice care under title XVIII.''.

SEC. 1615. ENHANCED PENALTIES FOR INDIVIDUALS EXCLUDED FROM PROGRAM PARTICIPATION.

(a) IN GENERAL.—Section 1128A(a) of the Social Security Act (42 U.S.C. 1320a–7a(a)), as amended by the previous sections, is further amended—

(1) by striking ''or'' at the end of paragraph (9);

(2) by inserting ''or'' at the end of paragraph (10);

(3) by inserting after paragraph (10) the following new paragraph:

''(11) orders or prescribes an item or service, including without limitation home health care, diagnostic and clinical lab tests, prescription drugs, durable medical equipment, ambulance services, physical or occupational therapy, or any other item or service, during a period when the person has been

excluded from participation in a Federal health care program, and the person knows or should know that a claim for such item or service will be presented to such a program;''; and

(4) in the matter following paragraph (11), as inserted by paragraph (2), by striking ''$15,000 for each day of the failure described in such paragraph'' and inserting ''$15,000 for each day of the failure described in such paragraph, or in cases under paragraph (11), $50,000 for each order or prescription for an item or service by an excluded individual''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to violations committed on or after January 1, 2010.

SEC. 1616. ENHANCED PENALTIES FOR PROVISION OF FALSE INFORMATION BY MEDICARE ADVANTAGE AND PART D PLANS.

(a) IN GENERAL.—Section 1857(g)(2)(A) of the Social Security Act (42 U.S.C. 1395w—27(g)(2)(A)) is amended by inserting ''except with respect to a determination under subparagraph (E), an assessment of not more than 3 times the amount claimed by such plan or plan sponsor based upon the misrepresentation or falsified information involved,'' after ''for each such determination,''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to violations committed on or after January 1, 2010.

SEC. 1617. ENHANCED PENALTIES FOR MEDICARE ADVANTAGE AND PART D MARKETING VIOLATIONS.

(a) IN GENERAL.—Section 1857(g)(1) of the Social Security Act (42 U.S.C. 1395w—27(g)(1)), as amended by section 1221(b), is amended—

(1) in subparagraph (G), by striking ''or'' at the end;

(2) by inserting after subparagraph (H) the following new subparagraphs:

''(I) except as provided under subparagraph (C) or (D) of section 1860D–1(b)(1), enrolls an individual in any plan under this part without the prior consent of the individual or the designee of the individual;

''(J) transfers an individual enrolled under this part from one plan to another without the prior consent of the individual or the designee of the individual or solely for the purpose of earning a commission;

''(K) fails to comply with marketing restrictions described in subsections (h) and (j) of

section 1851 or applicable implementing regulations or guidance; or

''(L) employs or contracts with any individual or entity who engages in the conduct described in subparagraphs (A) through (K) of this paragraph;''; and

(3) by adding at the end the following new sentence: ''The Secretary may provide, in addition to any other remedies authorized by law, for any of the remedies described in paragraph (2), if the Secretary determines that any employee or agent of such organization, or any provider or supplier who contracts with such organization, has engaged in any conduct described in subparagraphs (A) through (L) of this paragraph.''

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to violations committed on or after January 1, 2010.

SEC. 1618. ENHANCED PENALTIES FOR OBSTRUCTION OF PROGRAM AUDITS.

(a) IN GENERAL.—Section 1128(b)(2) of the Social Security Act (42 U.S.C. 1320a–7(b)(2)) is amended—

(1) in the heading, by inserting ''OR AUDIT'' after ''INVESTIGATION''; and

(2) by striking ''investigation into'' and all that follows through the period and inserting ''investigation or audit related to—''

''(i) any offense described in paragraph (1) or in subsection (a); or

''(ii) the use of funds received, directly or indirectly, from any Federal health care program (as defined in section 1128B(f)).''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to violations committed on or after January 1, 2010.

SEC. 1619. EXCLUSION OF CERTAIN INDIVIDUALS AND ENTITIES FROM PARTICIPATION IN MEDICARE AND STATE HEALTH CARE PROGRAMS.

(a) IN GENERAL.—Section 1128(c) of the Social Security Act, as previously amended by this division, is further amended—

(1) in the heading, by striking ''AND PERIOD'' and inserting ''PERIOD, AND EFFECT''; and

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

''(4)(A) For purposes of this Act, subject to subparagraph (C), the effect of exclusion is that no payment may be made by any Federal health care program (as defined

in section 1128B(f)) with respect to any item or service furnished—

''(i) by an excluded individual or entity; or

''(ii) at the medical direction or on the prescription of a physician or other authorized individual when the person submitting a claim for such item or service knew or had reason to know of the exclusion of such individual.

''(B) For purposes of this section and sections 1128A and 1128B, subject to subparagraph (C), an item or service has been furnished by an individual or entity if the individual or entity directly or indirectly provided, ordered, manufactured, distributed, prescribed, or otherwise supplied the item or service regardless of how the item or service was paid for by a Federal health care program or to whom such payment was made.

''(C)(i) Payment may be made under a Federal health care program for emergency items or services (not including items or services furnished in an emergency room of a hospital) furnished by an excluded individual or entity, or at the medical direction or on the prescription of an excluded physician or other authorized individual during the period of such individual's exclusion.

''(ii) In the case that an individual eligible for benefits under title XVIII or XIX submits a claim for payment

for items or services furnished by an excluded individual or entity, and such individual eligible for such benefits did not know or have reason to know that such excluded individual or entity was so excluded, then, notwithstanding such exclusion, payment shall be made for such items or services. In such case the Secretary shall notify such individual eligible for such benefits of the exclusion of the individual or entity furnishing the items or services. Payment shall not be made for items or services furnished by an excluded individual or entity to an individual eligible for such benefits after a reasonable time (as determined by the Secretary in regulations) after the Secretary has notified the individual eligible for such benefits of the exclusion of the individual or entity furnishing the items or services.

''(iii) In the case that a claim for payment for items or services furnished by an excluded individual or entity is submitted by an individual or entity other than an individual eligible for benefits under title XVIII or XIX or the excluded individual or entity, and the Secretary determines that the individual or entity that submitted the claim took reasonable steps to learn of the exclusion and reasonably relied upon inaccurate or misleading information from the relevant Federal health care program or its contractor, the Secretary may waive repayment of the

amount paid in violation of the exclusion to the individual or entity that submitted the claim for the items or services furnished by the excluded individual or entity. If a Federal health care program contractor provided inaccurate or misleading information that resulted in the waiver of an overpayment under this clause, the Secretary shall take appropriate action to recover the improperly paid amount from the contractor.''.

SEC. 1620. OIG AUTHORITY TO EXCLUDE FROM FEDERAL HEALTH CARE PROGRAMS OFFICERS AND OWNERS OF ENTITIES CONVICTED OF FRAUD.

Section 1128(b)(15)(A) of the Social Security Act (42 U.S.C. 1320a–7(b)(15)(A)) is amended—

(1) in clause (i)—

(A) by striking ''has'' and inserting ''had''; and

(B) by striking ''sanctioned entity and who knows or should know (as defined in section 1128A(i)(6)) of'' and inserting ''sanctioned entity at the time of, and who knew or should have known (as defined in section 1128A(i)(6)) of,'' ; and

(2) in clause (ii)—

(A) by striking ''is an officer'' and inserting ''was an officer''; and

(B) by inserting before the period the following: ''at the time of the action constituting the basis for the conviction or exclusion described in subparagraph (B)''.

SEC. 1621. SELF-REFERRAL DISCLOSURE PROTOCOL.

(a) DEVELOPMENT OF SELF-REFERRAL DISCLOSURE PROTOCOL.—

(1) IN GENERAL.—The Secretary of Health and Human Services, in cooperation with the Inspector General of the Department of Health and Human Services, shall establish, not later than 6 months after the date of the enactment of this Act, a protocol to enable health care providers of services and suppliers to disclose an actual or potential violation of section 1877 of the Social Security Act (42 U.S.C. 1395nn) pursuant to a self-referral disclosure protocol (in this section referred to as an ''SRDP''). The SRDP shall include direction to health care providers of services and suppliers on—

(A) a specific person, official, or office to whom such disclosures shall be made; and

(B) instruction on the implication of the SRDP on corporate integrity agreements and corporate compliance agreements.

(2) PUBLICATION ON INTERNET WEBSITE OF SRDP INFORMATION.—The Secretary shall post information on the public Internet website of the Centers for Medicare & Medicaid Services to inform relevant stakeholders of how to disclose actual or potential violations pursuant to an SRDP.

(3) RELATION TO ADVISORY OPINIONS.—The SRDP shall be separate from the advisory opinion process set forth in regulations implementing section 1877(g) of the Social Security Act.

(b) REDUCTION IN AMOUNTS OWED.—The Secretary is authorized to reduce the amount due and owing for all violations under section 1877 of the Social Security Act to an amount less than that specified in subsection (g) of such section. In establishing such amount for a violation, the Secretary may consider the following factors:

(1) The nature and extent of the improper or illegal practice.

(2) The timeliness of such self-disclosure.

(3) The cooperation in providing additional information related to the disclosure.

(4) Such other factors as the Secretary considers appropriate.

(c) REPORT.—Not later than 18 months after the date on which the SRDP protocol is established under sub-

section (a)(1), the Secretary shall submit to Congress a report on the implementation of this section. Such report shall include—

(1) the number of health care providers of services and suppliers making disclosures pursuant to an SRDP;

(2) the amounts collected pursuant to the SRDP;

(3) the types of violations reported under the SRDP; and

(4) such other information as may be necessary to evaluate the impact of this section.

(d) RELATION TO OTHER LAW AND REGULATION.—Nothing in this section shall affect the application of section 1128G(c) of the Social Security Act, as added by section 1641, except, in the case of a health care provider of services or supplier who is a person (as defined in paragraph (4) of such section 1128G(c)) who discloses an overpayment (as defined in such paragraph) to the Secretary of Health and Human Services pursuant to a SRDP established under this section, the 60-day period described in paragraph (2) of such section 1128G(c) shall be extended with respect to the return of an overpayment to the extent necessary for the Secretary to determine pursuant to the SRDP the amount due and owing.

Subtitle C—Enhanced Program and Provider Protections

SEC. 1631. ENHANCED CMS PROGRAM PROTECTION AUTHORITY.

(a) IN GENERAL.—Title XI of the Social Security Act (42 U.S.C. 1301 et seq.) is amended by inserting after section 1128F the following new section:

"SEC. 1128G. ENHANCED PROGRAM AND PROVIDER PROTECTIONS IN THE MEDICARE, MEDICAID, AND CHIP PROGRAMS.

''(a) CERTAIN AUTHORIZED SCREENING, ENHANCED OVERSIGHT PERIODS, AND ENROLLMENT MORATORIA.—

''(1) IN GENERAL.—For periods beginning after January 1, 2011, in the case that the Secretary determines there is a significant risk of fraudulent activity (as determined by the Secretary based on relevant complaints, reports, referrals by law enforcement or other sources, data analysis, trending information, or claims submissions by providers of services and suppliers) with respect to a category of provider of services or supplier of items or services, including a category within a geographic area, under title XVIII, XIX, or XXI, the Secretary may impose any of the following requirements with respect to a provider of services or a supplier (whether such pro-

vider or supplier is initially enrolling in the program or is renewing such enrollment):

''(A) Screening under paragraph (2).

''(B) Enhanced oversight periods under paragraph (3).

''(C) Enrollment moratoria under paragraph (4).

In applying this subsection for purposes of title XIX and XXI the Secretary may require a State to carry out the provisions of this subsection as a requirement of the State plan under title XIX or the child health plan under title XXI. Actions taken and determinations made under this subsection shall not be subject to review by a judicial tribunal.

''(2) SCREENING.—For purposes of paragraph (1), the Secretary shall establish procedures under which screening is conducted with respect to providers of services and suppliers described in such paragraph. Such screening may include—

''(A) licensing board checks;

''(B) screening against the list of individuals and entities excluded from the program under title XVIII, XIX, or XXI;

''(C) the excluded provider list system;

''(D) background checks; and

''(E) unannounced pre-enrollment or other site visits.

''(3) ENHANCED OVERSIGHT PERIOD.—For purposes of paragraph (1), the Secretary shall establish procedures to provide for a period of not less than 30 days and not more than 365 days during which providers of services and suppliers described in such paragraph, as the Secretary determines appropriate, would be subject to enhanced oversight, such as required or unannounced (or required and unannounced) site visits or inspections, prepayment review, enhanced review of claims, and such other actions as specified by the Secretary, under the programs under titles XVIII, XIX, and XXI. Under such procedures, the Secretary may extend such period for more than 365 days if the Secretary determines that after the initial period such additional period of oversight is necessary.

''(4) MORATORIUM ON ENROLLMENT OF PROVIDERS AND SUPPLIERS.—For purposes of paragraph (1), the Secretary, based upon a finding of a risk of serious ongoing fraud within a program under title XVIII, XIX, or XXI, may impose a moratorium on the enrollment of providers of services and suppliers within a category of providers of serv-

ices and suppliers (including a category within a specific geographic area) under such title. Such a moratorium may only be imposed if the Secretary makes a determination that the moratorium would not adversely impact access of individuals to care under such program.

''(5) CLARIFICATION.—Nothing in this subsection shall be interpreted to preclude or limit the ability of a State to engage in provider screening or enhanced provider oversight activities beyond those required by the Secretary.''.

(b) CONFORMING AMENDMENTS.—

(1) MEDICAID.—Section 1902(a) of the Social Security Act (42 U.S.C. 42 U.S.C. 1396a(a)) is amended—

(A) in paragraph (23), by inserting before the semicolon at the end the following: ''or by a person to whom or entity to which a moratorium under section 1128G(a)(4) is applied during the period of such moratorium'';

(B) in paragraph (72); by striking at the end ''and'';

(C) in paragraph (73), by striking the period at the end and inserting ''; and''; and

(D) by adding after paragraph (73) the following new paragraph:

''(74) provide that the State will enforce any determination made by the Secretary under subsection (a) of section 1128G (relating to a significant risk of fraudulent activity with respect to a category of provider or supplier described in such subsection (a) through use of the appropriate procedures described in such subsection (a)), and that the State will carry out any activities as required by the Secretary for purposes of such subsection (a).''.

(2) CHIP.—Section 2102 of such Act (42 U.S.C. 1397bb) is amended by adding at the end the following new subsection:

''(d) PROGRAM INTEGRITY.—A State child health plan shall include a description of the procedures to be used by the State—

''(1) to enforce any determination made by the Secretary under subsection (a) of section 1128G (relating to a significant risk of fraudulent activity with respect to a category of provider or supplier described in such subsection through use of the appropriate procedures described in such subsection); and

''(2) to carry out any activities as required by the Secretary for purposes of such subsection.''.

(3) MEDICARE.—Section 1866(j) of such Act (42 U.S.C. 1395cc(j)) is amended by adding at the end the following new paragraph:

''(3) PROGRAM INTEGRITY.—The provisions of section 1128G(a) apply to enrollments and renewals of enrollments of providers of services and suppliers under this title.''.

SEC. 1632. ENHANCED MEDICARE, MEDICAID, AND CHIP PROGRAM DISCLOSURE REQUIREMENTS RELATING TO PREVIOUS AFFILIATIONS.

(a) IN GENERAL.—Section 1128G of the Social Security Act, as inserted by section 1631, is amended by adding at the end the following new subsection:

''(b) ENHANCED PROGRAM DISCLOSURE REQUIREMENTS.—

''(1) DISCLOSURE.—A provider of services or supplier who submits on or after July 1, 2011, an application for enrollment and renewing enrollment in a program under title XVIII, XIX, or XXI shall disclose (in a form and manner determined by the Secretary) any current affiliation or affiliation within the previous 10-year period with a provider of services or supplier that has uncollected debt or with a person or entity that has been suspended or ex-

cluded under such program, subject to a payment suspension, or has had its billing privileges revoked.

''(2) ENHANCED SAFEGUARDS.—If the Secretary determines that such previous affiliation of such provider or supplier poses a risk of fraud, waste, or abuse, the Secretary may apply such enhanced safeguards as the Secretary determines necessary to reduce such risk associated with such provider or supplier enrolling or participating in the program under title XVIII, XIX, or XXI. Such safeguards may include enhanced oversight, such as enhanced screening of claims, required or unannounced (or required and unannounced) site visits or inspections, additional information reporting requirements, and conditioning such enrollment on the provision of a surety bond.

''(3) AUTHORITY TO DENY PARTICIPATION.—If the Secretary determines that there has been at least one such affiliation and that such affiliation or affiliations, as applicable, of such provider or supplier poses a serious risk of fraud, waste, or abuse, the Secretary may deny the application of such provider or supplier.''.

(b) CONFORMING AMENDMENTS.—

(1) MEDICAID.—Paragraph (74) of section 1902(a) of such Act (42 U.S.C. 1396a(a)), as added by section 1631(b)(1), is amended—

(A) by inserting ''or subsection (b) of such section (relating to disclosure requirements)'' before '', and that the State''; and

(B) by inserting before the period the following: ''and apply any enhanced safeguards, with respect to a provider or supplier described in such subsection (b), as the Secretary determines necessary under such subsection (b)''.

(2) CHIP.—Subsection (d) of section 2102 of such Act (42 U.S.C. 1397bb), as added by section 1631(b)(2), is amended—

(A) in paragraph (1), by striking at the end ''and'';

(B) in paragraph (2) by striking the period at the end and inserting ''; and' '' and

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

''(3) to enforce any determination made by the Secretary under subsection (b) of section 1128G (relating to disclosure requirements) and to apply any enhanced safeguards, with respect to a provider or

supplier described in such subsection, as the Secretary determines necessary under such subsection.''.

SEC. 1633. REQUIRED INCLUSION OF PAYMENT MODIFIER FOR CERTAIN EVALUATION AND MANAGEMENT SERVICES.

Section 1848 of the Social Security Act (42 U.S.C. 1395w–4), as amended by section 4101 of the HITECH Act (Public Law 111–5), is amended by adding at the end the following new subsection:

''(p) PAYMENT MODIFIER FOR CERTAIN EVALUATION AND MANAGEMENT SERVICES.—The Secretary shall establish a payment modifier under the fee schedule under this section for evaluation and management services (as specified in section 1842(b)(16)(B)(ii)) that result in the ordering of additional services (such as lab tests), the prescription of drugs, the furnishing or ordering of durable medical equipment in order to enable better monitoring of claims for payment for such additional services under this title, or the ordering, furnishing, or prescribing of other items and services determined by the Secretary to pose a high risk of waste, fraud, and abuse. The Secretary may require providers of services or suppliers to report such modifier in claims submitted for payment.''.

SEC. 1634. EVALUATIONS AND REPORTS REQUIRED UNDER MEDICARE INTEGRITY PROGRAM.

(a) IN GENERAL.—Section 1893(c) of the Social Security Act (42 U.S.C. 1395ddd(c)) is amended—

(1) in paragraph (3), by striking at the end ''and'';

(2) by redesignating paragraph (4) as paragraph (5); and

(3) by inserting after paragraph (3) the following new paragraph:

''(4) for the contract year beginning in 2011 and each subsequent contract year, the entity provides assurances to the satisfaction of the Secretary that the entity will conduct periodic evaluations of the effectiveness of the activities carried out by such entity under the Program and will submit to the Secretary an annual report on such activities; and''.

(b) REFERENCE TO MEDICAID INTEGRITY PROGRAM.—For a similar provision with respect to the Medicaid Integrity Program, see section 1752.

SEC. 1635. REQUIRE PROVIDERS AND SUPPLIERS TO ADOPT PROGRAMS TO REDUCE WASTE, FRAUD, AND ABUSE.

(a) IN GENERAL.—Section 1866(j) of the Social Security Act (42 U.S.C. 42 U.S.C. 1395cc(j)), as amended

by section 1631(d)(3), is further amended by adding at the end the following new paragraph:

''(4) COMPLIANCE PROGRAMS FOR PROVIDERS OF SERVICES AND SUPPLIERS.—

''(A) IN GENERAL.—The Secretary may not enroll (or renew the enrollment of) a provider of services or a supplier (other than a physician or a skilled nursing facility) under this title if such provider of services or supplier fails to, subject to subparagraph (E), establish a compliance program that contains the core elements established under subparagraph (B) and certify in a manner determined by the Secretary, that the provider or suppler has established such a program.

''(B) ESTABLISHMENT OF CORE ELEMENTS.—The Secretary, in consultation with the Inspector General of the Department of Health and Human Services, shall establish core elements for a compliance program under subparagraph (A). Such elements may include written policies, procedures, and standards of conduct, a designated compliance officer and a compliance committee; effective training and education pertaining to fraud, waste, and abuse

for the organization's employees, and contractors; a confidential or anonymous mechanism, such as a hotline, to receive compliance questions and reports of fraud, waste, or abuse; disciplinary guidelines for enforcement of standards; internal monitoring and auditing procedures, including monitoring and auditing of contractors; procedures for ensuring prompt responses to detected offenses and development of corrective action initiatives, including responses to potential offenses; and procedures to return all identified overpayments to the programs under this title, title XIX, and title XXI.

''(C) TIMELINE FOR IMPLEMENTATION.—The Secretary shall determine a timeline for the establishment of the core elements under subparagraph (B) and the date on which a provider of services and suppliers (other than physicians and skilled nursing facilities) shall be required to have established such a program for purposes of this subsection.

''(D) PILOT PROGRAM.—The Secretary may conduct a pilot program on the application of this subsection with respect to a category of providers of services or suppliers (other than

physicians and skilled nursing facilities) that the Secretary determines to be a category which is at high risk for waste, fraud, and abuse before implementing the requirements of this subsection to all providers of services and suppliers described in subparagraph (C).

''(E) TREATMENT OF SKILLED NURSING FACILITIES.—For the requirement for skilled nursing facilities to establish compliance and ethics programs see section 1819(d)(1)(C).

''(F) CONSTRUCTION.—Nothing in this subsection exempts a physician from participating in a compliance program established by a health care provider or other entity with which the physician is employed, under contract, or affiliated if such compliance is required by such provider or entity.''.

(b) REFERENCE TO SIMILAR MEDICAID PROVISION.—For a similar provision with respect to the Medicaid program under title XIX of the Social Security Act, see section 1753.

SEC. 1636. MAXIMUM PERIOD FOR SUBMISSION OF MEDICARE CLAIMS REDUCED TO NOT MORE THAN 12 MONTHS.

(a) PURPOSE.—In general, the 36-month period currently allowed for claims filing under parts A, B, C, and, D of title XVIII of the Social Security Act presents opportunities for fraud schemes in which processing patterns of the Centers for Medicare & Medicaid Services can be observed and exploited. Narrowing the window for claims processing will not overburden providers and will reduce fraud and abuse.

(b) REDUCING MAXIMUM PERIOD FOR SUBMISSION.—

(1) PART A.—Section 1814(a) of the Social Security Act (42 U.S.C. 1395f(a)) is amended—

(A) in paragraph (1), by striking ''period of 3 calendar years'' and all that follows and inserting ''period of 1 calendar year from which such services are furnished; and''; and

(B) by adding at the end the following new sentence: ''In applying paragraph (1), the Secretary may specify exceptions to the 1 calendar year period specified in such paragraph.''.

(2) PART B.—Section 1835(a) of such Act (42 U.S.C. 1395n(a)) is amended—

(A) in paragraph (1), by striking ''period of 3 calendar years'' and all that follows and inserting ''period of 1 calendar year from which such services are furnished; and''; and

(B) by adding at the end the following new sentence: ''In applying paragraph (1), the Secretary may specify exceptions to the 1 calendar year period specified in such paragraph.''.

(3) PARTS C AND D.—Section 1857(d) of such Act is amended by adding at the end the following new paragraph:

''(7) PERIOD FOR SUBMISSION OF CLAIMS.—The contract shall require an MA organization or PDP sponsor to require any provider of services under contract with, in partnership with, or affiliated with such organization or sponsor to ensure that, with respect to items and services furnished by such provider to an enrollee of such organization, written request, signed by such enrollee, except in cases in which the Secretary finds it impracticable for the enrollee to do so, is filed for payment for such items and services in such form, in such manner, and by such person or persons as the Secretary may by regulation prescribe, no later than the close of the 1 calendar year period after such items and

services are furnished. In applying the previous sentence, the Secretary may specify exceptions to the 1 calendar year period specified.''.

(c) EFFECTIVE DATE.—The amendments made by subsection (b) shall be effective for items and services furnished on or after January 1, 2011.

SEC. 1637. PHYSICIANS WHO ORDER DURABLE MEDICAL EQUIPMENT OR HOME HEALTH SERVICES REQUIRED TO BE MEDICARE ENROLLED PHYSICIANS OR ELIGIBLE PROFESSIONALS.

(a) DME.—Section 1834(a)(11)(B) of the Social Security Act (42 U.S.C. 1395m(a)(11)(B)) is amended by striking ''physician'' and inserting ''physician enrolled under section 1866(j) or other professional, as determined by the Secretary''.

(b) HOME HEALTH SERVICES.—

(1) PART A.—Section 1814(a)(2) of such Act (42 U.S.C. 1395(a)(2)) is amended in the matter preceding subparagraph (A) by inserting ''in the case of services described in subparagraph (C), a physician enrolled under section 1866(j) or other professional, as determined by the Secretary,'' before ''or, in the case of services''.

(2) PART B.—Section 1835(a)(2) of such Act (42 U.S.C. 1395n(a)(2)) is amended in the matter

preceding subparagraph (A) by inserting ", or in the case of services described in subparagraph (A), a physician enrolled under section 1866(j) or other professional, as determined by the Secretary," after "a physician".

(c) DISCRETION TO EXPAND APPLICATION.—The Secretary may extend the requirement applied by the amendments made by subsections (a) and (b) to durable medical equipment and home health services (relating to requiring certifications and written orders to be made by enrolled physicians and health professions) to other categories of items or services under this title, including covered part D drugs as defined in section 1860D–2(e), if the Secretary determines that such application would help to reduce the risk of waste, fraud, and abuse with respect to such other categories under title XVIII of the Social Security Act.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to written orders and certifications made on or after July 1, 2010.

SEC. 1638. REQUIREMENT FOR PHYSICIANS TO PROVIDE DOCUMENTATION ON REFERRALS TO PROGRAMS AT HIGH RISK OF WASTE AND ABUSE.

(a) PHYSICIANS AND OTHER SUPPLIERS.—Section 1842(h) of the Social Security Act is further amended by adding at the end the following new paragraph

''(9) The Secretary may disenroll, for a period of not more than one year for each act, a physician or supplier under section 1866(j) if such physician or supplier fails to maintain and, upon request of the Secretary, provide access to documentation relating to written orders or requests for payment for durable medical equipment, certifications for home health services, or referrals for other items or services written or ordered by such physician or supplier under this title, as specified by the Secretary.''.

(b) PROVIDERS OF SERVICES.—Section 1866(a)(1) of such Act (42 U.S.C. 1395cc), is amended—

(1) in subparagraph (U), by striking at the end ''and'';

(2) in subparagraph (V), by striking the period at the end and adding ''; and''; and

(3) by adding at the end the following new subparagraph:

''(W) maintain and, upon request of the Secretary, provide access to documentation relating to written orders or requests for payment

for durable medical equipment, certifications for home health services, or referrals for other items or services written or ordered by the provider under this title, as specified by the Secretary.''.

(c) OIG PERMISSIVE EXCLUSION AUTHORITY.—Section 1128(b)(11) of the Social Security Act (42 U.S.C. 1320a–7(b)(11)) is amended by inserting '', ordering, referring for furnishing, or certifying the need for'' after ''furnishing''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to orders, certifications, and referrals made on or after January 1, 2010.

SEC. 1639. FACE-TO-FACE ENCOUNTER WITH PATIENT REQUIRED BEFORE ELIGIBILITY CERTIFICATIONS FOR HOME HEALTH SERVICES OR DURABLE MEDICAL EQUIPMENT.

(a) CONDITION OF PAYMENT FOR HOME HEALTH SERVICES.—

(1) PART A.—Section 1814(a)(2)(C) of such Act is amended—

(A) by striking ''and such services'' and inserting ''such services''; and

(B) by inserting after ''care of a physician'' the following: '', and, in the case of a cer-

tification or recertification made by a physician after January 1, 2010, prior to making such certification the physician must document that the physician has had a face-to-face encounter (including through use of telehealth and other than with respect to encounters that are incident to services involved) with the individual during the 6-month period preceding such certification, or other reasonable timeframe as determined by the Secretary''.

(2) PART B.—Section 1835(a)(2)(A) of the Social Security Act is amended—

(A) by striking ''and'' before ''(iii)''; and

(B) by inserting after ''care of a physician'' the following: '', and (iv) in the case of a certification or recertification after January 1, 2010, prior to making such certification the physician must document that the physician has had a face-to-face encounter (including through use of telehealth and other than with respect to encounters that are incident to services involved) with the individual during the 6-month period preceding such certification or recertification, or other reasonable timeframe as determined by the Secretary''.

(b) CONDITION OF PAYMENT FOR DURABLE MEDICAL EQUIPMENT.—Section 1834(a)(11)(B) of the Social Security Act (42 U.S.C. 1395m(a)(11)(B)) is amended by adding before the period at the end the following: ''and shall require that any written order required for payment under this subsection be written only pursuant to the eligible health care professional authorized to make such written order documenting that such professional has had a face-to-face encounter (including through use of telehealth and other than with respect to encounters that are incident to services involved) with the individual involved during the 6-month period preceding such written order, or other reasonable timeframe as determined by the Secretary''.

(c) APPLICATION TO OTHER AREAS UNDER MEDICARE.—The Secretary may apply a face-to-face encounter requirement similar to the requirement described in the amendments made by subsections (a) and (b) to other items and services for which payment is provided under title XVIII of the Social Security Act based upon a finding that such a decision would reduce the risk of waste, fraud, or abuse.

(d) APPLICATION TO MEDICAID AND CHIP.—The face-to-face encounter requirements described in the amendments made by subsections (a) and (b) and any ex-

panded application of similar requirements pursuant to subsection (c) shall apply with respect to a certification or recertification for home health services under title XIX or XXI of the Social Security Act, a written order for durable medical equipment under such title, and any other applicable item or service identified pursuant to subsection (c) for which payment is made under such title, respectively, in the same manner and to the same extent as such requirements apply in the case of such a certification or recertification, written order, or other applicable item or service so identified, respectively, under title XVIII of such Act.

SEC. 1640. EXTENSION OF TESTIMONIAL SUBPOENA AUTHORITY TO PROGRAM EXCLUSION INVESTIGATIONS.

(a) IN GENERAL.—Section 1128(f) of the Social Security Act (42 U.S.C. 1320a-7(f)) is amended by adding at the end the following new paragraph:

''(4) The provisions of subsections (d) and (e) of section 205 shall apply with respect to this section to the same extent as they are applicable with respect to title II. The Secretary may delegate the authority granted by section 205(d) (as made applicable to this section) to the Inspector General of the Department of Health and Human Services or the Administrator of the Centers for

Medicare & Medicaid Services for purposes of any investigation under this section.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to investigations beginning on or after January 1, 2010.

SEC. 1641. REQUIRED REPAYMENTS OF MEDICARE AND MEDICAID OVERPAYMENTS.

Section 1128G of the Social Security Act, as inserted by section 1631 and amended by section 1632, is further amended by adding at the end the following new subsection:

''(c) REPORTS ON AND REPAYMENT OF OVERPAYMENTS IDENTIFIED THROUGH INTERNAL AUDITS AND REVIEWS.—

''(1) REPORTING AND RETURNING OVERPAYMENTS.—If a person knows of an overpayment, the person must—

''(A) report and return the overpayment to the Secretary, the State, an intermediary, a carrier, or a contractor, as appropriate, at the correct address, and

''(B) notify the Secretary, the State, intermediary, carrier, or contractor to whom the overpayment was returned in writing of the reason for the overpayment.

''(2) TIMING.—Subject to section 1620(d) of the Affordable Health Care for America Act, an overpayment must be reported and returned under paragraph (1)(A) by not later than the date that is 60 days after the date the person knows of the overpayment.

Any known overpayment retained later than the applicable date specified in this paragraph creates an obligation as defined in section 3729(b)(3) of title 31 of the United States Code.

''(3) CLARIFICATION.—Repayment of any overpayments (or refunding by withholding of future payments) by a provider of services or supplier does not otherwise limit the provider or supplier's potential liability for administrative obligations such as applicable interests, fines, and penalties or civil or criminal sanctions involving the same claim if it is determined later that the reason for the overpayment was related to fraud or other intentional conduct by the provider or supplier or the employees or agents of such provider or supplier.

''(4) DEFINITIONS.—In this subsection:

''(A) KNOWS.—The term 'knows' has the meaning given the terms 'knowing' and 'know-

ingly' in section 3729(b) of title 31 of the United States Code.

''(B) OVERPAYMENT.—The term ''overpayment'' means any funds that a person receives or retains under title XVIII, XIX, or XXI to which the person, after applicable reconciliation (pursuant to the applicable existing process under the respective title), is not entitled under such title.

''(C) PERSON.—The term 'person' means a provider of services, supplier, Medicaid managed care organization (as defined in section 1903(m)(1)(A)), Medicare Advantage organization (as defined in section 1859(a)(1)), or PDP sponsor (as defined in section 1860D–41(a)(13)), but excluding a beneficiary.''.

SEC. 1642. EXPANDED APPLICATION OF HARDSHIP WAIVERS FOR OIG EXCLUSIONS TO BENEFICIARIES OF ANY FEDERAL HEALTH CARE PROGRAM.

Section 1128(c)(3)(B) of the Social Security Act (42 U.S.C. 1320a–7(c)(3)(B)) is amended by striking ''individuals entitled to benefits under part A of title XVIII or enrolled under part B of such title, or both'' and insert-

ing ''beneficiaries (as defined in section 1128A(i)(5)) of that program''.

SEC. 1643. ACCESS TO CERTAIN INFORMATION ON RENAL DIALYSIS FACILITIES.

Section 1881(b) of the Social Security Act (42 U.S.C. 1395rr(b)) is amended by adding at the end the following new paragraph:

''(15) For purposes of evaluating or auditing payments made to renal dialysis facilities for items and services under this section under paragraph (1), each such renal dialysis facility, upon the request of the Secretary, shall provide to the Secretary access to information relating to any ownership or compensation arrangement between such facility and the medical director of such facility or between such facility and any physician.''.

SEC. 1644. BILLING AGENTS, CLEARINGHOUSES, OR OTHER ALTERNATE PAYEES REQUIRED TO REGISTER UNDER MEDICARE.

(a) MEDICARE.—Section 1866(j)(1) of the Social Security Act (42 U.S.C. 1395cc(j)(1)) is amended by adding at the end the following new subparagraph:

''(D) BILLING AGENTS AND CLEARINGHOUSES REQUIRED TO BE REGISTERED UNDER MEDICARE.—Any agent, clearinghouse, or other alternate payee that submits claims on behalf of

a health care provider must be registered with the Secretary in a form and manner specified by the Secretary.''.

(b) MEDICAID.—For a similar provision with respect to the Medicaid program under title XIX of the Social Security Act, see section 1759.

(c) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to claims submitted on or after January 1, 2012.

SEC. 1645. CONFORMING CIVIL MONETARY PENALTIES TO FALSE CLAIMS ACT AMENDMENTS.

Section 1128A of the Social Security Act, as amended by sections 1611, 1612, 1613, and 1615, is further amended—

(1) in subsection (a)—

(A) in paragraph (1), by striking ''to an officer, employee, or agent of the United States, or of any department or agency thereof, or of any State agency (as defined in subsection (i)(1))'';

(B) in paragraph (4)—

(i) in the matter preceding subparagraph (A), by striking ''participating in a program under title XVIII or a State health care program'' and inserting ''par-

ticipating in a Federal health care program (as defined in section 1128B(f))''; and

(ii) in subparagraph (A), by striking ''title XVIII or a State health care program'' and inserting ''a Federal health care program (as defined in section 1128B(f))'';

(C) by striking ''or'' at the end of paragraph (10);

(D) by inserting after paragraph (11) the following new paragraphs:

''(12) conspires to commit a violation of this section; or

''(13) knowingly makes, uses, or causes to be made or used, a false record or statement material to an obligation to pay or transmit money or property to a Federal health care program, or knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to a Federal health care program;''; and

(E) in the matter following paragraph (13), as inserted by subparagraph (D)—

(i) by striking ''or'' before ''in cases under paragraph (11)''; and

(ii) by inserting ", in cases under paragraph (12), $50,000 for any violation described in this section committed in furtherance of the conspiracy involved; or in cases under paragraph (13), $50,000 for each false record or statement, or concealment, avoidance, or decrease'' after ''by an excluded individual''; and

(F) in the second sentence, by striking ''such false statement, omission, or misrepresentation)'' and inserting ''such false statement or misrepresentation, in cases under paragraph (12), an assessment of not more than 3 times the total amount that would otherwise apply for any violation described in this section committed in furtherance of the conspiracy involved, or in cases under paragraph (13), an assessment of not more than 3 times the total amount of the obligation to which the false record or statement was material or that was avoided or decreased)''.

(2) in subsection (c)(1), by striking ''six years'' and inserting ''10 years''; and

(3) in subsection (i)—

(A) by amending paragraph (2) to read as follows:

''(2) The term 'claim' means any application, request, or demand, whether under contract, or otherwise, for money or property for items and services under a Federal health care program (as defined in section 1128B(f)), whether or not the United States or a State agency has title to the money or property, that—

''(A) is presented or caused to be presented to an officer, employee, or agent of the United States, or of any department or agency thereof, or of any State agency (as defined in subsection (i)(1)); or

''(B) is made to a contractor, grantee, or other recipient if the money or property is to be spent or used on the Federal health care program's behalf or to advance a Federal health care program interest, and if the Federal health care program—

''(i) provides or has provided any portion of the money or property requested or demanded; or

''(ii) will reimburse such contractor, grantee, or other recipient for any portion

of the money or property which is requested or demanded.'';

(B) by amending paragraph (3) to read as follows:

''(3) The term 'item or service' means, without limitation, any medical, social, management, administrative, or other item or service used in connection with or directly or indirectly related to a Federal health care program.'';

(C) in paragraph (6)—

(i) in subparagraph (C), by striking at the end ''or'';

(ii) in the first subparagraph (D), by striking at the end the period and inserting ''; or''; and

(iii) by redesignating the second subparagraph (D) as a subparagraph (E);

(D) by amending paragraph (7) to read as follows:

''(7) The terms 'knowing', 'knowingly', and 'should know' mean that a person, with respect to information—

''(A) has actual knowledge of the information;

''(B) acts in deliberate ignorance of the truth or falsity of the information; or

''(C) acts in reckless disregard of the truth or falsity of the information;

and require no proof of specific intent to defraud.''; and

(E) by adding at the end the following new paragraphs:

''(8) The term 'obligation' means an established duty, whether or not fixed, arising from an express or implied contractual, grantor-grantee, or licensor-licensee relationship, from a fee-based or similar relationship, 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.''.

SEC. 1646. REQUIRING PROVIDER AND SUPPLIER PAYMENTS UNDER MEDICARE TO BE MADE THROUGH DIRECT DEPOSIT OR ELECTRONIC FUNDS TRANSFER (EFT) AT INSURED DEPOSITORY INSTITUTIONS.

(a) MEDICARE.—Section 1874 of the Social Security Act (42 U.S.C. 1395kk) is amended by adding at the end the following new subsection:

''(e) LIMITATION ON PAYMENT TO PROVIDERS OF SERVICES AND SUPPLIERS.—No payment shall be made under this title for items and services furnished by a provider of services or supplier unless each payment to the provider of services or supplier is in the form of direct deposit or electronic funds transfer to the provider of services' or supplier's account, as applicable, at a depository institution (as defined in section 19(b)(1)(A) of the Federal Reserve Act.''.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to each payment made to a provider of services, provider, or supplier on or after such date (not later than July 1, 2012) as the Secretary of Health and Human Services shall specify, regardless of when the items and services for which such payment is made were furnished.

SEC. 1647. INSPECTOR GENERAL FOR THE HEALTH CHOICES ADMINISTRATION.

(a) ESTABLISHMENT; APPOINTMENT.—There is hereby established an Office of Inspector General for the Health Choices Administration, to be headed by the Inspector General for the Health Choices Administration to be appointed by the President, by and with the advice and consent of the Senate.

(b) AMENDMENTS TO THE INSPECTOR GENERAL ACT OF 1978.—

(1) APPLICATION TO HEALTH CHOICES ADMINISTRATION.—Section 12 of the Inspector General Act of 1978 (5 U.S.C. App.) is amended—

(A) in paragraph (1), by striking ''or the Federal Cochairpersons of the Commissions established under section 15301 of title 40, United States Code'' and inserting ''the Federal Cochairpersons of the Commissions established under section 15301 of title 40, United States Code; or the Commissioner of the Health Choices Administration established under section 241 of the Affordable Health Care for America Act''; and

(B) in paragraph (2), by striking ''or the Commissions established under section 15301 of title 40, United States Code'' and inserting

''the Commissions established under section 15301 of title 40, United States Code, or the Health Choices Administration established under section 241 of the Affordable Health Care for America Act''.

(2) SPECIAL PROVISIONS RELATING TO HEALTH CHOICES ADMINISTRATION AND HHS.—The Inspector General Act of 1978 (5 U.S.C. App.) is further amended by inserting after section 8L the following new section:

''SEC. 8M SPECIAL PROVISIONS RELATING TO THE HEALTH CHOICES ADMINISTRATION AND THE DEPARTMENT OF HEALTH AND HUMAN SERVICES.

''(a) The Inspector General of the Health Choices Administration shall—

''(1) have the authority to conduct, supervise, and coordinate audits, evaluations, and investigations of the programs and operations of the Health Choices Administration established under section 241 of the Affordable Health Care for America Act, including matters relating to fraud, abuse, and misconduct in connection with the admission and continued participation of any health benefits plan par-

ticipating in the Health Insurance Exchange established under section 301 of such Act;

''(2) have the authority to conduct audits, evaluations, and investigations relating to any private Exchange-participating health benefits plan, as defined in section 201(c) of such Act;

''(3) have the authority, in consultation with the Office of Inspector General for the Department of Health and Human Services and subject to subsection (b), to conduct audits, evaluations, and investigations relating to the public health insurance option established under section 321 of such Act; and

''(4) have access to all relevant records necessary to carry out this section, including records relating to claims paid by Exchange-participating health benefits plans.

''(b) Authority granted to the Health Choices Administration and the Inspector General of the Health Choices Administration by the Affordable Health Care for America Act does not limit the duties, authorities, and responsibilities of the Office of Inspector General for the Department of Health and Human Services, as in existence as of the date of the enactment of the Affordable Health Care for America Act , to oversee programs and operations of such

department. The Office of Inspector General for the Department of Health and Human Services retains primary jurisdiction over fraud and abuse in connection with payments made under the public health insurance option established under section 321 of such Act and administered by the Department of Health and Human Services.''.

(3) APPLICATION OF RULE OF CONSTRUCTION.—Section 8J of the Inspector General Act of 1978 (5 U.S.C. App.) is amended by striking ''or 8H'' and inserting '', 8H, or 8M''.

(c) EFFECTIVE DATE.—The provisions of and amendments made by this section shall take effect on the date of the enactment of this Act.

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

SEC. 1651. ACCESS TO INFORMATION NECESSARY TO IDENTIFY FRAUD, WASTE, AND ABUSE.

(a) GAO ACCESS.—Subchapter II of chapter 7 of title 31, United States Code, is amended by adding at the end the following:

''§ 721. Access to certain information

''No provision of the Social Security Act shall be construed to limit, amend, or supersede the authority of the Comptroller General to obtain any information, to inspect

any record, or to interview any officer or employee under section 716 of this title, including with respect to any information disclosed to or obtained by the Secretary of Health and Human Services under part C or D of title XVIII of the Social Security Act.''.

(b) ACCESS TO MEDICARE PART D DATA PROGRAM INTEGRITY PURPOSES.—

(1) PROVISION OF INFORMATION AS CONDITION OF PAYMENT.—Section 1860D–15(d)(2)(B) of the Social Security Act (42 U.S.C. 1395w–115(d)(2)(B)) is amended—

(A) by striking ''may be used by officers'' and all that follows through the period and inserting ''may be used by—''; and

(B) by adding at the end the following clauses:

''(i) officers, employees, and contractors of the Department of Health and Human Services only for the purposes of, and to the extent necessary in, carrying out this section; and

''(ii) the Inspector General of the Department of Health and Human Services, the Administrator of the Centers for Medicare & Medicaid Services, and the Attorney

General only for the purposes of protecting the integrity of the programs under this title and title XIX; conducting the activities described in section 1893 and subparagraphs (A) through (E) of section 1128C(a)(1); and for investigation, audit, evaluation, oversight, and law enforcement purposes to the extent consistent with applicable law.''.

(2) GENERAL DISCLOSURE OF INFORMATION.—Section 1860D–15(f)(2) of the Social Security Act (42 U.S.C. 1395w–115(f)(2)) is amended—

(A) by striking ''may be used by officers'' and all that follows through the period and inserting ''may be used by—''; and

(B) by adding at the end the following subparagraphs:

''(A) officers, employees, and contractors of the Department of Health and Human Services only for the purposes of, and to the extent necessary in, carrying out this section; and

''(B) the Inspector General of the Department of Health and Human Services, the Administrator of the Centers for Medicare & Medicaid Services, and the Attorney General only

for the purposes of protecting the integrity of the programs under this title and title XIX; conducting the activities described in section 1893 and subparagraphs (A) through (E) of section 1128C(a)(1); and for investigation, audit, evaluation, oversight, and law enforcement purposes to the extent consistent with applicable law.''.

SEC. 1652. ELIMINATION OF DUPLICATION BETWEEN THE HEALTHCARE INTEGRITY AND PROTECTION DATA BANK AND THE NATIONAL PRACTITIONER DATA BANK.

(a) IN GENERAL.—To eliminate duplication between the Healthcare Integrity and Protection Data Bank (HIPDB) established under section 1128E of the Social Security Act and the National Practitioner Data Bank (NPBD) established under the Health Care Quality Improvement Act of 1986, section 1128E of the Social Security Act (42 U.S.C. 1320a-7e) is amended—

(1) in subsection (a), by striking ''Not later than'' and inserting ''Subject to subsection (h), not later than'';

(2) in the first sentence of subsection (d)(2), by striking ''(other than with respect to requests by Federal agencies)''; and

(3) by adding at the end the following new subsection:

''(h) SUNSET OF THE HEALTHCARE INTEGRITY AND PROTECTION DATA BANK; TRANSITION PROCESS.—Effective upon the enactment of this subsection, the Secretary shall implement a process to eliminate duplication between the Healthcare Integrity and Protection Data Bank (in this subsection referred to as the 'HIPDB' established pursuant to subsection (a) and the National Practitioner Data Bank (in this subsection referred to as the 'NPDB') as implemented under the Health Care Quality Improvement Act of 1986 and section 1921 of this Act, including systems testing necessary to ensure that information formerly collected in the HIPDB will be accessible through the NPDB, and other activities necessary to eliminate duplication between the two data banks. Upon the completion of such process, notwithstanding any other provision of law, the Secretary shall cease the operation of the HIPDB and shall collect information required to be reported under the preceding provisions of this section in the NPDB. Except as otherwise provided in this subsection, the provisions of subsections (a) through (g) shall continue to apply with respect to the reporting of (or failure to report), access to, and other treatment of the information specified in this section.''.

(b) ELIMINATION OF THE RESPONSIBILITY OF THE HHS OFFICE OF THE INSPECTOR GENERAL.—Section 1128C(a)(1) of the Social Security Act (42 U.S.C. 1320a-7c(a)(1)) is amended—

(1) in subparagraph (C), by adding at the end ''and'';

(2) in subparagraph (D), by striking at the end '', and'' and inserting a period; and

(3) by striking subparagraph (E).

(c) SPECIAL PROVISION FOR ACCESS TO THE NATIONAL PRACTITIONER DATA BANK BY THE DEPARTMENT OF VETERANS AFFAIRS.—

(1) IN GENERAL.—Notwithstanding any other provision of law, during the one year period that begins on the effective date specified in subsection (e)(1), the information described in paragraph (2) shall be available from the National Practitioner Data Bank (described in section 1921 of the Social Security Act) to the Secretary of Veterans Affairs without charge.

(2) INFORMATION DESCRIBED.—For purposes of paragraph (1), the information described in this paragraph is the information that would, but for the amendments made by this section, have been avail-

able to the Secretary of Veterans Affairs from the Healthcare Integrity and Protection Data Bank.

(d) FUNDING.—Notwithstanding any provisions of this Act, sections 1128E(d)(2) and 1817(k)(3) of the Social Security Act, or any other provision of law, there shall be available for carrying out the transition process under section 1128E(h) of the Social Security Act over the period required to complete such process, and for operation of the National Practitioner Data Bank until such process is completed, without fiscal year limitation—

(1) any fees collected pursuant to section 1128E(d)(2) of such Act; and

(2) such additional amounts as necessary, from appropriations available to the Secretary and to the Office of the Inspector General of the Department of Health and Human Services under clauses (i) and (ii), respectively, of section 1817(k)(3)(A) of such Act, for costs of such activities during the first 12 months following the date of the enactment of this Act.

(e) EFFECTIVE DATE.—The amendments made—

(1) by subsection (a)(2) shall take effect on the first day after the Secretary of Health and Human Services certifies that the process implemented pur-

suant to section 1128E(h) of the Social Security Act (as added by subsection (a)(3)) is complete; and

(2) by subsection (b) shall take effect on the earlier of the date specified in paragraph (1) or the first day of the second succeeding fiscal year after the fiscal year during which this Act is enacted.

SEC. 1653. COMPLIANCE WITH HIPAA PRIVACY AND SECURITY STANDARDS.

The provisions of sections 262(a) and 264 of the Health Insurance Portability and Accountability Act of 1996 (and standards promulgated pursuant to such sections) and the Privacy Act of 1974 shall apply with respect to the provisions of this subtitle and amendments made by this subtitle.

TITLE VII—MEDICAID AND CHIP

SEC. 1. TABLE OF CONTENTS [*TEMPORARY*].

Subtitle A—Medicaid and Health Reform

SEC. 1701. ELIGIBILITY FOR INDIVIDUALS WITH INCOME BELOW 150 PERCENT OF THE FEDERAL POVERTY LEVEL.

(a) ELIGIBILITY FOR NON-TRADITIONAL INDIVIDUALS WITH INCOME BELOW 150 PERCENT OF THE FEDERAL POVERTY LEVEL.—

(1) FULL MEDICAID BENEFITS FOR NON-MEDICARE ELIGIBLE INDIVIDUALS.—Section

1902(a)(10)(A)(i) of the Social Security Act (42 U.S.C. 1396b(a)(10)(A)(i)) is amended—

(A) by striking ''or'' at the end of subclause (VI);

(B) by adding ''or'' at the end of subclause (VII); and

(C) by adding at the end the following new subclause:

''(VIII) who are under 65 years of age, who are not described in a previous subclause of this clause, who are not entitled to hospital insurance benefits under part A of title XVIII, and whose family income (determined using methodologies and procedures specified by the Secretary in consultation with the Health Choices Commissioner) does not exceed 150 percent of the income official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved;''.

(2) MEDICARE COST SHARING ASSISTANCE FOR MEDICARE-ELIGIBLE INDIVIDUALS.—Section 1902(a)(10)(E) of such Act (42 U.S.C. 1396b(a)(10)(E)) is amended—

(A) in clause (iii), by striking ''and'' at the end;

(B) in clause (iv), by adding ''and'' at the end; and

(C) by adding at the end the following new clause:

''(v) for making medical assistance available for medicare cost-sharing described in subparagraphs (B) and (C) of section 1905(p)(3), for individuals under 65 years of age who would be qualified medicare beneficiaries described in section 1905(p)(1) but for the fact that their income exceeds the income level established by the State under section 1905(p)(2) but is less than 150 percent of the official poverty line (referred to in such section) for a family of the size involved; and''.

(3) INCREASED FMAP FOR NON-TRADITIONAL FULL MEDICAID ELIGIBLE INDIVIDUALS.—Section 1905 of such Act (42 U.S.C. 1396d) is amended—

(A) in the first sentence of subsection (b), by striking ''and'' before ''(4)'' and by inserting before the period at the end the following: '', and (5) 100 percent (for periods before 2015 and 91 percent for periods beginning with 2015) with respect to amounts described in subsection (y)''; and

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

''(y) ADDITIONAL EXPENDITURES SUBJECT TO INCREASED FMAP.—For purposes of section 1905(b)(5), the amounts described in this subsection are the following:

''(1) Amounts expended for medical assistance for individuals described in subclause (VIII) of section 1902(a)(10)(A)(i).''.

(4) CONSTRUCTION.—Nothing in this subsection shall be construed as not providing for coverage under subparagraph (A)(i)(VIII) or (E)(v) of section 1902(a)(10) of the Social Security Act, as added by paragraphs (1) and (2), or an increased FMAP under the amendments made by paragraph (3), for an individual who has been provided medical assistance under title XIX of the Act under a demonstration waiver approved under section 1115 of such Act or with State funds.

(5) CONFORMING AMENDMENTS.—

(A) Section 1903(f)(4) of the Social Security Act (42 U.S.C. 1396b(f)(4)) is amended—

(i) by inserting ''1902(a)(10)(A)(i)(VIII),'' after ''1902(a)(10)(A)(i)(VII),''; and

(ii) by inserting ''1902(a)(10)(E)(v),'' before ''1905(p)(1)''.

(B) Section 1905(a) of such Act (42 U.S.C. 1396d(a)), as amended by sections 1714(a)(4) and 1731(c), is further amended, in the matter preceding paragraph (1)—

(i) by striking ''or'' at the end of clause (xiv);

(ii) by adding ''or'' at the end of clause (xv); and

(iii) by inserting after clause (xv) the following:

''(xvi) individuals described in section 1902(a)(10)(A)(i)(VIII),''.

(b) ELIGIBILITY FOR TRADITIONAL MEDICAID ELIGIBLE INDIVIDUALS WITH INCOME NOT EXCEEDING 150 PERCENT OF THE FEDERAL POVERTY LEVEL .—

(1) IN GENERAL.—Section 1902(a)(10)(A)(i) of the Social Security Act (42 U.S.C.

1396b(a)(10)(A)(i)), as amended by subsection (a), is amended—

(A) by striking ''or'' at the end of subclause (VII); and

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

''(IX) who are over 18, and under 65 years of age, who would be eligible for medical assistance under the State plan under subclause (I) or section 1931 (based on the income standards, methodologies, and procedures in effect as of June 16, 2009) but for income, who are in families whose income does not exceed 150 percent of the income official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved; or

''(X) beginning with 2014, who are over 5, and under 19, years of age, who would be eligible for medical

assistance under the State plan under subclause (I) or (VII) (based on the income standards, methodologies, and procedures in effect as of June 16, 2009) but for income, who are in families whose income does not exceed 150 percent of the income official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved; or

''(XI) beginning with 2014, who are under 19 years of age, who are not described in subclause (X), and who would be eligible for child health assistance under a State child health plan insofar as such plan provides benefits under this title (as described in section 2101(a)(2)) based on such plan as in effect as of June 16, 2009; or''.

(2) INCREASED FMAP FOR CERTAIN TRADITIONAL MEDICAID ELIGIBLE INDIVIDUALS.—

(A) INCREASED FMAP FOR ADULTS.—Section 1905(y) of such Act (42 U.S.C. 1396d(y)), as added by subsection (a)(2)(B), is amended by inserting ''or (IX)'' after ''(VIII)''.

(B) ENHANCED FMAP FOR CHILDREN.—Section 1905(b)(4) of such Act is amended by inserting ''1902(a)(10)(A)(i)(X), 1902(a)(10)(A)(i)(XI), or'' after ''on the basis of section''.

(3) CONSTRUCTION.—Nothing in this subsection shall be construed as not providing for coverage under subclause (IX), (X), or (XI) of section 1902(a)(10)(A)(i) of the Social Security Act, as added by paragraph (1), or an increased or enhanced FMAP under the amendments made by paragraph (2), for an individual who has been provided medical assistance under title XIX of the Act under a demonstration waiver approved under section 1115 of such Act or with State funds.

(4) CONFORMING AMENDMENT.—Section 1903(f)(4) of the Social Security Act (42 U.S.C. 1396b(f)(4)), as amended by subsection (a)(4), is amended by inserting ''1902(a)(10)(A)(i)(IX), 1902(a)(10)(A)(i)(X), 1902(a)(10)(A)(i)(XI),'' after ''1902(a)(10)(A)(i)(VIII),''.

(c) INCREASED MATCHING RATE FOR TEMPORARY COVERAGE OF CERTAIN NEWBORNS.—Section 1905(y) of such Act, as added by subsection (a)(3)(B), is amended by adding at the end the following:

''(2) Amounts expended for medical assistance for children described in section 305(d)(1) of the Affordable Health Care for America Act during the time period specified in such section.''.

(d) NETWORK ADEQUACY.—Section 1932(a)(2) of the Social Security Act (42 U.S.C. 1396u–2(a)(2)) is amended by adding at the end the following new subparagraph:

''(D) ENROLLMENT OF NON-TRADITIONAL MEDICAID ELIGIBLES.—A State may not require under paragraph (1) the enrollment in a managed care entity of an individual described in section 1902(a)(10)(A)(i)(VIII) unless the State demonstrates, to the satisfaction of the Secretary, that the entity, through its provider network and other arrangements, has the capacity to meet the health, mental health, and substance abuse needs of such individuals.''.

(e) EFFECTIVE DATE.—The amendments made by this section shall take effect on the first day of Y1, and

shall apply with respect to items and services furnished on or after such date.

SEC. 1702. REQUIREMENTS AND SPECIAL RULES FOR CERTAIN MEDICAID ELIGIBLE INDIVIDUALS.

(a) IN GENERAL.—Title XIX of the Social Security Act is amended by adding at the end the following new section:

'' REQUIREMENTS AND SPECIAL RULES FOR CERTAIN MEDICAID ELIGIBLE INDIVIDUALS

''SEC. 1943. (a) COORDINATION WITH NHI EXCHANGE THROUGH MEMORANDUM OF UNDERSTANDING.—

''(1) IN GENERAL.—The State shall enter into a Medicaid memorandum of understanding described in section 305(e)(2) of the Affordable Health Care for America Act with the Health Choices Commissioner, acting in consultation with the Secretary, with respect to coordinating the implementation of the provisions of division A of such Act with the State plan under this title in order to ensure the enrollment of Medicaid eligible individuals in acceptable coverage. Nothing in this section shall be construed as permitting such memorandum to modify or vitiate any requirement of a State plan under this title.

''(2) ENROLLMENT OF EXCHANGE-REFERRED INDIVIDUALS.—

''(A) NON-TRADITIONAL INDIVIDUALS.—Pursuant to such memorandum the State shall accept without further determination the enrollment under this title of an individual determined by the Commissioner to be a non-traditional Medicaid eligible individual. The State shall not do any redeterminations of eligibility for such individuals unless the periodicity of such redeterminations is consistent with the periodicity for redeterminations by the Commissioner of eligibility for affordability credits under subtitle C of title II of division A of the Affordable Health Care for America Act, as specified under such memorandum.

''(B) TRADITIONAL INDIVIDUALS.—Pursuant to such memorandum, the State shall accept without further determination the enrollment under this title of an individual determined by the Commissioner to be a traditional Medicaid eligible individual. The State may do redeterminations of eligibility of such individual consistent with such section and the memorandum.

''(3) DETERMINATIONS OF ELIGIBILITY FOR AFFORDABILITY CREDITS.—If the Commissioner determines that a State Medicaid agency has the capacity to make determinations of eligibility for affordability credits under subtitle C of title II of division A of the Affordable Health Care for America Act, under such memorandum—

''(A) the State Medicaid agency shall conduct such determinations for any Exchange-eligible individual who requests such a determination;

''(B) in the case that a State Medicaid agency determines that an Exchange-eligible individual is not eligible for affordability credits, the agency shall forward the information on the basis of which such determination was made to the Commissioner; and

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

''(4) REFERRALS UNDER MEMORANDUM.—Pursuant to such memorandum, if an individual applies to the State for assistance in obtaining health coverage and the State determines that the individual is not eligible for medical assistance under this title

and is not authorized under such memorandum to make an determination with respect to eligibility for coverage and affordability credits through the Health Insurance Exchange, the State shall refer the individual to the Commissioner for a determination of such eligibility and, with the individual's authorization, provide to the Commissioner information obtained by the State as part of the application process.

''(5) ADDITIONAL TERMS.—Such memorandum shall include such additional provisions as are necessary to implement efficiently the provisions of this section and title II of division A of the Affordable Health Care for America Act.

''(b) TREATMENT OF CERTAIN NEWBORNS.—

''(1) IN GENERAL.—In the case of a child who is deemed under section 305(d) of the Affordable Health Care for America Act to be a Medicaid eligible individual and enrolled under this title pursuant to such section, the State shall provide for a determination, by not later than the end of the period referred to in paragraph (2) of such section, of the child's eligibility for medical assistance under this title.

''(2) EXTENDED TREATMENT AS TRADITIONAL MEDICAID ELIGIBLE INDIVIDUAL.—In accordance with paragraph (2) of section 305(d) of the Affordable Health Care for America Act, in the case of a child described in paragraph (1) of such section who at the end of the period referred to in such paragraph is not otherwise covered under acceptable coverage, the child shall be deemed (until such time as the child obtains such coverage or the State otherwise makes a determination of the child's eligibility for medical assistance under its plan under this title pursuant to paragraph (1)) to be a Medicaid eligible individual described in section 1902(l)(1)(B).

''(c) DEFINITIONS.—In this section:

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

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

''(A) a Medicaid eligible individual by reason of the application of subclause (VIII) of

section 1902(a)(10)(A)(i) of the Social Security Act; or

''(B) a childless adult not described in section 1902(a)(10)(A) or (C) of such Act (as in effect as of the day before the date of the enactment of this Act).

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

''(4) MEMORANDUM.—The term 'memorandum' means a Medicaid memorandum of understanding under section 305(e)(2) of the Affordable Health Care for America Act.

''(5) Y1.—The term 'Y1' has the meaning given such term in section 100(c) of the Affordable Health Care for America Act.''.

(b) CONFORMING AMENDMENTS TO ERROR RATE.—

(1) Section 1903(u)(1)(D) of the Social Security Act (42 U.S.C. 1396b(u)(1)(D)) is amended by adding at the end the following new clause:

''(vi) In determining the amount of erroneous excess payments, there shall not be included any erroneous payments made that are attributable to an error in an eligi-

bility determination under subtitle C of title II of division A of the Affordable Health Care for America Act.''.

(2) Section 2105(c)(11) of such Act (42 U.S.C. 1397ee(c)(11)) is amended by adding at the end the following new sentence: ''Clause (vi) of section 1903(u)(1)(D) shall apply with respect to the application of such requirements under this title and title XIX.''.

SEC. 1703. CHIP AND MEDICAID MAINTENANCE OF ELIGIBILITY.

(a) CHIP MAINTENANCE OF ELIGIBILITY.—Section 1902 of the Social Security Act (42 U.S.C. 1396a) is amended—

(1) in subsection (a), as amended by section 1631(b)(1)(D)—

(A) by striking ''and'' at the end of paragraph (73);

(B) by striking the period at the end of paragraph (74) and inserting ''; and''; and

(C) by inserting after paragraph (74) the following new paragraph:

''(75) provide for maintenance of effort under the State child health plan under title XXI in accordance with subsection (gg).''; and

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

''(gg) CHIP MAINTENANCE OF ELIGIBILITY REQUIREMENT.—

''(1) IN GENERAL.—Subject to paragraph (2), as a condition of its State plan under this title under subsection (a)(75) and receipt of any Federal financial assistance under section 1903(a) for calendar quarters beginning after the date of the enactment of this subsection and before CHIP MOE termination date specified in paragraph (3), a State shall not have in effect eligibility standards, methodologies, or procedures under its State child health plan under title XXI (including any waiver under such title or demonstration project under section 1115) that are more restrictive than the eligibility standards, methodologies, or procedures, respectively, under such plan (or waiver) as in effect on June 16, 2009.

''(2) LIMITATION.—Paragraph (1) shall not be construed as preventing a State from imposing a limitation described in section 2110(b)(5)(C)(i)(II) for a fiscal year in order to limit expenditures under its State child health plan under title XXI to those

for which Federal financial participation is available under section 2105 for the fiscal year.

''(3) CHIP MOE TERMINATION DATE.—In paragraph (1), the 'CHIP MOE termination date' for a State is the date that is the last day of Y1 (as defined in section 100(c) of the Affordable Health Care for America Act).

''(4) CHIP TRANSITION REPORT.—Not later than December 31, 2011, the Secretary shall submit to Congress a report—

''(A) that compares the benefits packages offered under an average State child health plan under title XXI in 2011 and to the benefit standards initially adopted under section 224(b) of the Affordable Health Care for America Act and for affordability credits under subtitle C of title II of division C of such Act; and

''(B) that includes such recommendations as may be necessary to ensure that—

''(i) such coverage is at least comparable to the coverage provided to children under such an average State child health plan; and

''(ii) there are procedures in effect for the enrollment of CHIP enrollees (includ-

ing CHIP-eligible pregnant women) at the end of Y1 under this title, into a qualified health benefits plan offered through the Health Insurance Exchange, or into other acceptable coverage (as defined for purposes of such Act) without interruption of coverage or a written plan of treatment.''.

(b) MEDICAID MAINTENANCE OF EFFORT; SIMPLIFYING AND COORDINATING ELIGIBILITY RULES BETWEEN EXCHANGE AND MEDICAID.—

(1) IN GENERAL.—Section 1903 of such Act (42 U.S.C. 1396b) is amended by adding at the end the following new subsection:

''(aa) MAINTENANCE OF MEDICAID EFFORT; SIMPLIFYING AND COORDINATING ELIGIBILITY RULES BETWEEN HEALTH INSURANCE EXCHANGE AND MEDICAID.—

''(1) MAINTENANCE OF EFFORT.—

''(A) IN GENERAL.—Subject to subparagraph (B), a State is not eligible for payment under subsection (a) for a calendar quarter beginning after the date of the enactment of this subsection if eligibility standards, methodologies, or procedures under its plan under this title (including any waiver under this title or

demonstration project under section 1115) that are more restrictive than the eligibility standards, methodologies, or procedures, respectively, under such plan (or waiver) as in effect on June 16, 2009. The Secretary shall extend such a waiver (including the availability of Federal financial participation under such waiver) for such period as may be required for a State to meet the requirement of the previous sentence.

''(B) EXCEPTION FOR CERTAIN DEMONSTRATION PROJECTS.—In the case of a State demonstration project under section 1115 in effect on June 16, 2009, that permits individuals to be eligible solely to receive a premium or cost-sharing subsidy for individual or group health insurance coverage, effective for coverage provided in Y1—

''(i) the Secretary shall permit the State to amend such waiver to apply more restrictive eligibility standards, methodologies, or procedures with respect to such individuals under such waiver; and

''(ii) the application of such more restrictive, standards, methodologies, or procedures under such an amendment shall

not be considered in violation of the requirement of subparagraph (A).

''(2) REMOVAL OF ASSET TEST FOR CERTAIN ELIGIBILITY CATEGORIES.—

''(A) IN GENERAL.—A State is not eligible for payment under subsection (a) for a calendar quarter beginning on or after the first day of Y1 (as defined in section 100(c) of the Affordable Health Care for America Act), if the State applies any asset or resource test in determining (or redetermining) eligibility of any individual on or after such first day under any of the following:

''(i) Subclause (I), (III), (IV), (VI), (VIII), (IX), (X), or (XI) of section 1902(a)(10)(A)(i).

''(ii) Subclause (II), (IX), (XIV) or (XVII) of section 1902(a)(10)(A)(ii).

''(iii) Section 1931(b).

''(B) OVERRIDING CONTRARY PROVISIONS; REFERENCES.—The provisions of this title that prevent the waiver of an asset or resource test described in subparagraph (A) are hereby waived.

''(C) REFERENCES.—Any reference to a provision described in a provision in subparagraph (A) shall be deemed to be a reference to such provision as modified through the application of subparagraphs (A) and (B).''.

(2) CONFORMING AMENDMENTS.—(A) Section 1902(a)(10)(A) of such Act (42 U.S.C. 1396a(a)(10)(A)) is amended, in the matter before clause (i), by inserting ''subject to section 1903(aa)(2),'' after ''(A)''.

(B) Section 1931(b)(1) of such Act (42 U.S.C. 1396u–1(b)(1)) is amended by inserting ''and section 1903(aa)(2)'' after ''and (3)''.

(c) STANDARDS FOR BENCHMARK PACKAGES.—Section 1937(b) of such Act (42 U.S.C. 1396u–7(b)) is amended—

(1) in each of paragraphs (1) and (2), by inserting ''subject to paragraph (5),'' after ''subsection (a)(1),''; and

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

''(5) MINIMUM STANDARDS.—Effective January 1, 2013, any benchmark benefit package (or benchmark equivalent coverage under paragraph (2)) must meet the minimum benefits and cost-sharing

standards of a basic plan offered through the Health Insurance Exchange.''.

(d) REPEAL OF CHIP.—Section 2104(a) of the Social Security Act is amended by inserting at the end the following:

''No funds shall be appropriated or authorized to be appropriated under this section for fiscal year 2014 and subsequent years.''.

SEC. 1704. REDUCTION IN MEDICAID DSH.

(a) REPORT.—

(1) IN GENERAL.—Not later than January 1, 2016, the Secretary of Health and Human Services (in this title referred to as the ''Secretary'') shall submit to Congress a report concerning the extent to which, based upon the impact of the health care reforms carried out under division A in reducing the number of uninsured individuals, there is a continued role for Medicaid DSH. In preparing the report, the Secretary shall consult with community-based health care networks serving low-income beneficiaries.

(2) MATTERS TO BE INCLUDED.—The report shall include the following:

(A) RECOMMENDATIONS.—Recommendations regarding—

(i) the appropriate targeting of Medicaid DSH within States; and

(ii) the distribution of Medicaid DSH among the States, taking into account the ratio of the amount of DSH funds allocated to a State to the number of uninsured individuals in such State.

(B) SPECIFICATION OF DSH HEALTH REFORM METHODOLOGY.—The DSH Health Reform methodology described in paragraph (2) of subsection (b) for purposes of implementing the requirements of such subsection.

(3) COORDINATION WITH MEDICARE DSH REPORT.—The Secretary shall coordinate the report under this subsection with the report on Medicare DSH under section 1112.

(4) MEDICAID DSH.—In this section, the term ''Medicaid DSH'' means adjustments in payments under section 1923 of the Social Security Act for inpatient hospital services furnished by disproportionate share hospitals.

(b) MEDICAID DSH REDUCTIONS.—

(1) REDUCTIONS.—

(A) IN GENERAL.—For each of fiscal years 2017 through 2019 the Secretary shall effect the following reductions:

(i) REDUCTION DSH ALLOTMENTS.—The Secretary shall reduce DSH allotments to States in the amount specified under the DSH health reform methodology under paragraph (2) for the State for the fiscal year.

(ii) REDUCTIONS IN PAYMENTS.—The Secretary shall reduce payments to States under section 1903(a) of the Social Security Act (42 U.S.C. 1396b(a)) for each calendar quarter in the fiscal year, in the manner specified in subparagraph (C), in an amount equal to ¼ of the DSH allotment reduction under clause (i) for the State for the fiscal year.

(B) AGGREGATE REDUCTIONS.—The aggregate reductions in DSH allotments for all States under subparagraph (A)(i) shall be equal to—

(i) $1,500,000,000 for fiscal year 2017;

(ii) $2,500,000,000 for fiscal year 2018; and

(iii) $6,000,000,000 for fiscal year 2019.

The Secretary shall distribute such aggregate reduction among States in accordance with paragraph (2).

(C) MANNER OF PAYMENT REDUCTION.—The amount of the payment reduction under subparagraph (A)(ii) for a State for a quarter shall be deemed an overpayment to the State under title XIX of the Social Security Act to be disallowed against the State's regular quarterly draw for all Medicaid spending under section 1903(d)(2) of such Act (42 U.S.C. 1396b(d)(2)). Such a disallowance is not subject to a reconsideration under 1116(d) of such Act (42 U.S.C. 1316(d)).

(D) DEFINITIONS.—In this section:

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

(ii) DSH ALLOTMENT.—The term ''DSH allotment'' means, with respect to a State for a fiscal year, the allotment made

under section 1923(f) of the Social Security Act (42 U.S.C. 1396r–4(f)) to the State for the fiscal year.

(2) DSH HEALTH REFORM METHODOLOGY.—The Secretary shall carry out paragraph (1) through use of a DSH Health Reform methodology issued by the Secretary that imposes the largest percentage reductions on the States that—

(A) have the lowest percentages of uninsured individuals (determined on the basis of audited hospital cost reports) during the most recent year for which such data are available; or

(B) do not target their DSH payments on—

(i) hospitals with high volumes of Medicaid inpatients (as defined in section 1923(b)(1)(A) of the Social Security Act (42 U.S.C. 1396r–4(b)(1)(A)); and

(ii) hospitals that have high levels of uncompensated care (excluding bad debt).

(3) DSH ALLOTMENT PUBLICATIONS.—

(A) IN GENERAL.—Not later than the publication deadline specified in subparagraph (B), the Secretary shall publish in the Federal Reg-

ister a notice specifying the DSH allotment to each State under 1923(f) of the Social Security Act for the respective fiscal year specified in such subparagraph, consistent with the application of the DSH Health Reform methodology described in paragraph (2).

(B) PUBLICATION DEADLINE.—The publication deadline specified in this subparagraph is—

(i) January 1, 2016, with respect to DSH allotments described in subparagraph (A) for fiscal year 2017;

(ii) January 1, 2017, with respect to DSH allotments described in subparagraph (A) for fiscal year 2018; and

(iii) January 1, 2018, with respect to DSH allotments described in subparagraph (A) for fiscal year 2019.

(c) CONFORMING AMENDMENTS.—

(1) Section 1923(f) of the Social Security Act (42 U.S.C. 1396r–4(f)) is amended—

(A) by redesignating paragraph (7) as paragraph (8); and

(B) by inserting after paragraph (6) the following new paragraph:

''(7) SPECIAL RULE FOR FISCAL YEARS 2017, 2018, AND 2019.—For each of fiscal years 2017, 2018, and 2018, the DSH allotments under this subsection are subject to reduction under section 1704(b) of the Affordable Health Care for America Act.''.

(2) The second sentence of section 1923(b)(4) of such Act (42 U.S.C. 1396r–4(b)(4)) is amended by inserting before the period the following: ''or to affect the authority of the Secretary to issue and implement the DSH Health Reform methodology under section 1704(b)(2) of the Affordable Health Care for America Act''.

(d) DISPROPORTIONATE SHARE HOSPITALS (DSH) AND ESSENTIAL ACCESS HOSPITAL (EAH) NON-DISCRIMINATION.—

(1) IN GENERAL.—Section 1923(d) of the Social Security Act (42 U.S.C. 1396r-4) is amended by adding at the end the following new paragraph:

''(4) No hospital may be defined or deemed as a disproportionate share hospital, or as an essential access hospital (for purposes of subsection (f)(6)(A)(iv)), under a State plan under this title or subsection (b) of this section (including any dem-

onstration project under section 1115) unless the hospital—

''(A) provides services to beneficiaries under this title without discrimination on the ground of race, color, national origin, creed, source of payment, status as a beneficiary under this title, or any other ground unrelated to such beneficiary's need for the services or the availability of the needed services in the hospital; and

''(B) makes arrangements for, and accepts, reimbursement under this title for services provided to eligible beneficiaries under this title.''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to expenditures made on or after July 1, 2010.

SEC. 1705. EXPANDED OUTSTATIONING.

(a) IN GENERAL.—Section 1902(a)(55) of the Social Security Act (42 U.S.C. 1396a(a)(55)) is amended by striking ''under subsection (a)(10)(A)(i)(IV), (a)(10)(A)(i)(VI), (a)(10)(A)(i)(VII), or (a)(10)(A)(ii)(IX)'' and inserting ''(including receipt and processing of applications of individuals for affordability credits under subtitle C of title II of division A of the Affordable Health Care for America Act pursuant to a Med-

icaid memorandum of understanding under section 1943(a)(1))''.

(b) EFFECTIVE DATE.—Except as provided in section 1790, the amendment made by subsection (a) shall apply to services furnished on or after July 1, 2010, without regard to whether or not final regulations to carry out such amendment have been promulgated by such date.

Subtitle B—Prevention

SEC. 1711. REQUIRED COVERAGE OF PREVENTIVE SERVICES.

(a) COVERAGE.—Section 1905 of the Social Security Act (42 U.S.C. 1396d), as amended by section 1701(a)(3)(B), is amended—

(1) in subsection (a)(4)—

(A) by striking ''and'' before ''(C)''; and

(B) by inserting before the semicolon at the end the following: ''; and (D) preventive services described in subsection (z)''; and

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

''(z) PREVENTIVE SERVICES.—The preventive services described in this subsection are services not otherwise described in subsection (a) or (r) that the Secretary determines are—

''(1)(A) recommended with a grade of A or B by the Task Force for Clinical Preventive Services; or

''(B) vaccines recommended for use as appropriate by the Director of the Centers for Disease Control and Prevention; and

''(2) appropriate for individuals entitled to medical assistance under this title.''.

(b) ELIMINATION OF COST-SHARING.—

(1) Subsections (a)(2)(D) and (b)(2)(D) of section 1916 of such Act (42 U.S.C. 1396o) are each amended by inserting ''preventive services described in section 1905(z),'' after ''emergency services (as defined by the Secretary),''.

(2) Section 1916A(a)(1) of such Act (42 U.S.C. 1396o–1 (a)(1)) is amended by inserting '', preventive services described in section 1905(z),'' after ''subsection (c)''.

(c) CONFORMING AMENDMENT.—Section 1928 of such Act (42 U.S.C. 1396s) is amended—

(1) in subsection (c)(2)(B)(i), by striking ''the advisory committee referred to in subsection (e)'' and inserting ''the Director of the Centers for Disease Control and Prevention'';

(2) in subsection (e), by striking ''Advisory Committee'' and all that follows and inserting ''Director of the Centers for Disease Control and Prevention.''; and

(3) by striking subsection (g).

(d) EFFECTIVE DATE.—Except as provided in section 1790, the amendments made by this section shall apply to services furnished on or after July 1, 2010, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.

SEC. 1712. TOBACCO CESSATION.

(a) DROPPING TOBACCO CESSATION EXCLUSION FROM COVERED OUTPATIENT DRUGS.—Section 1927(d)(2) of the Social Security Act (42 U.S.C. 1396r–8(d)(2)) is amended—

(1) by striking subparagraph (E);

(2) in subparagraph (G), by inserting before the period at the end the following: '', except agents approved by the Food and Drug Administration for purposes of promoting, and when used to promote, tobacco cessation''; and

(3) by redesignating subparagraphs (F) through (K) as subparagraphs (E) through (J), respectively.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to drugs and services furnished on or after January 1, 2010.

SEC. 1713. OPTIONAL COVERAGE OF NURSE HOME VISITATION SERVICES.

(a) IN GENERAL.—Section 1905 of the Social Security Act (42 U.S.C. 1396d), as amended by sections 1701(a)(3)(B) and 1711(a), is amended—

(1) in subsection (a)—

(A) in paragraph (27), by striking ''and'' at the end;

(B) by redesignating paragraph (28) as paragraph (29); and

(C) by inserting after paragraph (27) the following new paragraph:

''(28) nurse home visitation services (as defined in subsection (aa)); and''; and

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

''(aa) The term 'nurse home visitation services' means home visits by trained nurses to families with a first-time pregnant woman, or a child (under 2 years of age), who is eligible for medical assistance under this title, but only, to the extent determined by the Secretary based

upon evidence, that such services are effective in one or more of the following:

''(1) Improving maternal or child health and pregnancy outcomes or increasing birth intervals between pregnancies.

''(2) Reducing the incidence of child abuse, neglect, and injury, improving family stability (including reduction in the incidence of intimate partner violence), or reducing maternal and child involvement in the criminal justice system.

''(3) Increasing economic self-sufficiency, employment advancement, school-readiness, and educational achievement, or reducing dependence on public assistance.''.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after January 1, 2010.

(c) CONSTRUCTION.—Nothing in the amendments made by this section shall be construed as affecting the ability of a State under title XIX or XXI of the Social Security Act to provide nurse home visitation services as part of another class of items and services falling within the definition of medical assistance or child health assistance under the respective title, or as an administrative expenditure for which payment is made under section

1903(a) or 2105(a) of such Act, respectively, on or after the date of the enactment of this Act.

SEC. 1714. STATE ELIGIBILITY OPTION FOR FAMILY PLANNING SERVICES.

(a) COVERAGE AS OPTIONAL CATEGORICALLY NEEDY GROUP.—

(1) IN GENERAL.—Section 1902(a)(10)(A)(ii) of the Social Security Act (42 U.S.C. 1396a(a)(10)(A)(ii)) is amended—

(A) in subclause (XVIII), by striking ''or'' at the end;

(B) in subclause (XIX), by adding ''or'' at the end; and

(C) by adding at the end the following new subclause:

''(XX) who are described in subsection (hh) (relating to individuals who meet certain income standards);''.

(2) GROUP DESCRIBED.—Section 1902 of such Act (42 U.S.C. 1396a), as amended by section 1703, is amended by adding at the end the following new subsection:

''(hh)(1) Individuals described in this subsection are individuals—

''(A) whose income does not exceed an income eligibility level established by the State that does not exceed the highest income eligibility level established under the State plan under this title (or under its State child health plan under title XXI) for pregnant women; and

''(B) who are not pregnant.

''(2) At the option of a State, individuals described in this subsection may include individuals who, had individuals applied on or before January 1, 2007, would have been made eligible pursuant to the standards and processes imposed by that State for benefits described in clause (XV) of the matter following subparagraph (G) of section subsection (a)(10) pursuant to a demonstration project waiver granted under section 1115.

''(3) At the option of a State, for purposes of subsection (a)(17)(B), in determining eligibility for services under this subsection, the State may consider only the income of the applicant or recipient.''.

(3) LIMITATION ON BENEFITS.—Section 1902(a)(10) of such Act (42 U.S.C. 1396a(a)(10)) is amended in the matter following subparagraph (G)—

(A) by striking ''and (XIV)'' and inserting ''(XIV)''; and

(B) by inserting ", and (XV) the medical assistance made available to an individual described in subsection (hh) shall be limited to family planning services and supplies described in section 1905(a)(4)(C) including medical diagnosis and treatment services that are provided pursuant to a family planning service in a family planning setting'' after ''cervical cancer''.

(4) CONFORMING AMENDMENTS.—Section 1905(a) of such Act (42 U.S.C. 1396d(a)), as amended by section 1731(c), is amended in the matter preceding paragraph (1)—

(A) in clause (xiii), by striking ''or'' at the end;

(B) in clause (xiv), by adding ''or'' at the end; and

(C) by inserting after clause (xiv) the following:

''(xv) individuals described in section 1902(hh),''.

(b) PRESUMPTIVE ELIGIBILITY.—

(1) IN GENERAL.—Title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) is amended by inserting after section 1920B the following:

''PRESUMPTIVE ELIGIBILITY FOR FAMILY PLANNING SERVICES

''SEC. 1920C. (a) STATE OPTION.—State plan approved under section 1902 may provide for making medical assistance available to an individual described in section 1902(hh) (relating to individuals who meet certain income eligibility standard) during a presumptive eligibility period. In the case of an individual described in section 1902(hh), such medical assistance shall be limited to family planning services and supplies described in 1905(a)(4)(C) and, at the State's option, medical diagnosis and treatment services that are provided in conjunction with a family planning service in a family planning setting.

''(b) DEFINITIONS.—For purposes of this section:

''(1) PRESUMPTIVE ELIGIBILITY PERIOD.—The term 'presumptive eligibility period' means, with respect to an individual described in subsection (a), the period that—

''(A) begins with the date on which a qualified entity determines, on the basis of preliminary information, that the individual is described in section 1902(hh); and

''(B) ends with (and includes) the earlier of—

''(i) the day on which a determination is made with respect to the eligibility of such individual for services under the State plan; or

''(ii) in the case of such an individual who does not file an application by the last day of the month following the month during which the entity makes the determination referred to in subparagraph (A), such last day.

''(2) QUALIFIED ENTITY.—

''(A) IN GENERAL.—Subject to subparagraph (B), the term 'qualified entity' means any entity that—

''(i) is eligible for payments under a State plan approved under this title; and

''(ii) is determined by the State agency to be capable of making determinations of the type described in paragraph (1)(A).

''(B) RULE OF CONSTRUCTION.—Nothing in this paragraph shall be construed as preventing a State from limiting the classes of entities that may become qualified entities in order to prevent fraud and abuse.

''(c) ADMINISTRATION.—

''(1) IN GENERAL.—The State agency shall provide qualified entities with—

''(A) such forms as are necessary for an application to be made by an individual described in subsection (a) for medical assistance under the State plan; and

''(B) information on how to assist such individuals in completing and filing such forms.

''(2) NOTIFICATION REQUIREMENTS.—A qualified entity that determines under subsection (b)(1)(A) that an individual described in subsection (a) is presumptively eligible for medical assistance under a State plan shall—

''(A) notify the State agency of the determination within 5 working days after the date on which determination is made; and

''(B) inform such individual at the time the determination is made that an application for medical assistance is required to be made by not later than the last day of the month following the month during which the determination is made.

''(3) APPLICATION FOR MEDICAL ASSISTANCE.—In the case of an individual described in subsection (a) who is determined by a qualified enti-

ty to be presumptively eligible for medical assistance under a State plan, the individual shall apply for medical assistance by not later than the last day of the month following the month during which the determination is made.

''(d) PAYMENT.—Notwithstanding any other provision of law, medical assistance that—

''(1) is furnished to an individual described in subsection (a)—

''(A) during a presumptive eligibility period;

''(B) by a entity that is eligible for payments under the State plan; and

''(2) is included in the care and services covered by the State plan,

shall be treated as medical assistance provided by such plan for purposes of clause (4) of the first sentence of section 1905(b).''.

(2) CONFORMING AMENDMENTS.—

(A) Section 1902(a)(47) of the Social Security Act (42 U.S.C. 1396a(a)(47)) is amended by inserting before the semicolon at the end the following: ''and provide for making medical assistance available to individuals described in subsection (a) of section 1920C during a pre-

sumptive eligibility period in accordance with such section''.

(B) Section 1903(u)(1)(D)(v) of such Act (42 U.S.C. 1396b(u)(1)(D)(v)) is amended—

(i) by striking ''or for'' and inserting ''for''; and

(ii) by inserting before the period the following: '', or for medical assistance provided to an individual described in subsection (a) of section 1920C during a presumptive eligibility period under such section''.

(c) CLARIFICATION OF COVERAGE OF FAMILY PLANNING SERVICES AND SUPPLIES.—Section 1937(b) of the Social Security Act (42 U.S.C. 1396u–7(b)), as amended by section 1703(c)(2), is amended by adding at the end the following:

''(6) COVERAGE OF FAMILY PLANNING SERVICES AND SUPPLIES.—Notwithstanding the previous provisions of this section, a State may not provide for medical assistance through enrollment of an individual with benchmark coverage or benchmark-equivalent coverage under this section unless such coverage includes for any individual described in section 1905(a)(4)(C), medical assistance for family plan-

ning services and supplies in accordance with such section.''.

(d) EFFECTIVE DATE.—The amendments made by this section take effect on the date of the enactment of this Act and shall apply to items and services furnished on or after such date.

Subtitle C—Access

SEC. 1721. PAYMENTS TO PRIMARY CARE PRACTITIONERS.

(a) IN GENERAL.—

(1) FEE-FOR-SERVICE PAYMENTS.—Section 1902 of the Social Security Act (42 U.S.C. 1396b)as amended by sections 1703(a), 1714(a), 1731(a), and 1746, is amended—

(A) in subsection (a)(13)—

(i) by striking ''and'' at the end of subparagraph (A);

(ii) by adding ''and'' at the end of subparagraph (B); and

(iii) by adding at the end the following new subparagraph:

''(C) payment for primary care services (as defined in subsection (kk)(1)) furnished by physicians (or for services furnished by other health care professionals that would be primary care services under such section if furnished by

a physician) at a rate not less than 80 percent of the payment rate that would be applicable if the adjustment described in subsection (kk)(2) were to apply to such services and physicians or professionals (as the case may be) under part B of title XVIII for services furnished in 2010, 90 percent of such adjusted payment rate for services and physicians (or professionals) furnished in 2011, or 100 percent of such adjusted payment rate for services and physicians (or professionals) furnished in 2012 and each subsequent year;''; and

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

''(kk) INCREASED PAYMENT FOR PRIMARY CARE SERVICES.—For purposes of subsection (a)(13)(C):

''(1) PRIMARY CARE SERVICES DEFINED.—The term 'primary care services' means evaluation and management services, without regard to the specialty of the physician furnishing the services, that are procedure codes (for services covered under title XVIII) for services in the category designated Evaluation and Management in the Health Care Common Procedure Coding System (established by the Secretary under section 1848(c)(5) as of December

31, 2009, and as subsequently modified by the Secretary).

''(2) ADJUSTMENT.—The adjustment described in this paragraph is the substitution of 1.25 percent for the update otherwise provided under section 1848(d)(4) for each year beginning with 2010.''.

(2) UNDER MEDICAID MANAGED CARE PLANS.—Section 1932(f) of such Act (42 U.S.C. 1396u–2(f)) is amended—

(A) in the heading, by adding at the end the following: ''; ADEQUACY OF PAYMENT FOR PRIMARY CARE SERVICES''; and

(B) by inserting before the period at the end the following: ''and, in the case of primary care services described in section 1902(a)(13)(C), consistent with the minimum payment rates specified in such section (regardless of the manner in which such payments are made, including in the form of capitation or partial capitation)''.

(b) INCREASE IN PAYMENT USING INCREASED FMAP.—Section 1905(y) of the Social Security Act, as added by section 1701(a)(3)(B) and as amended by section 1701(c)(2), is amended by adding at the end the following:

''(3)(A) The portion of the amounts expended for medical assistance for services described in section 1902(a)(13)(C) furnished on or after January 1, 2010, that is attributable to the amount by which the minimum payment rate required under such section (or, by application, section 1932(f)) exceeds the payment rate applicable to such services under the State plan as of June 16, 2009.

''(B) Subparagraph (A) shall not be construed as preventing the payment of Federal financial participation based on the Federal medical assistance percentage for amounts in excess of those specified under such subparagraph.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after January 1, 2010.

SEC. 1722. MEDICAL HOME PILOT PROGRAM.

(a) IN GENERAL.—The Secretary of Health and Human Services shall establish under this section a medical home pilot program under which a State may apply to the Secretary for approval of a medical home pilot project described in subsection (b) (in this section referred to as a ''pilot project'') for the application of the medical home concept under title XIX of the Social Security Act.

The pilot program shall operate for a period of up to 5 years.

(b) PILOT PROJECT DESCRIBED.—

(1) IN GENERAL.—A pilot project is a project that applies one or more of the medical home models described in section 1866F(a)(3) of the Social Security Act (as inserted by section 1302(a)) or such other model as the Secretary may approve, to individuals (including medically fragile children and high-risk pregnant women) who are eligible for medical assistance under title XIX of the Social Security Act. The Secretary shall provide for appropriate coordination of the pilot program under this section with the medical home pilot program under section 1866F of such Act.

(2) LIMITATION.—A pilot project shall be for a duration of not more than 5 years.

(3) CONSIDERATION FOR CERTAIN TECHNOLOGIES.—In considering applications for pilots projects under this section, the Secretary may approve a project which tests the effectiveness of applications and devices, such as wireless patient management technologies, that are approved by the Food and Drug Administration and enable providers and

practitioners to communicate directly with their patients in managing chronic illness.

(c) ADDITIONAL INCENTIVES.—In the case of a pilot project, the Secretary may—

(1) waive the requirements of section 1902(a)(1) of the Social Security Act (relating to statewideness) and section 1902(a)(10)(B) of such Act (relating to comparability); and

(2) increase to up to 90 percent (for the first 2 years of the pilot program) or 75 percent (for the next 3 years) the matching percentage for administrative expenditures (such as those for community care workers).

(d) MEDICALLY FRAGILE CHILDREN.—In the case of a model involving medically fragile children, the model shall ensure that the patient-centered medical home services received by each child, in addition to fulfilling the requirements under 1866F(b)(1) of the Social Security Act, provide for continuous involvement and education of the parent or caregiver and for assistance to the child in obtaining necessary transitional care if a child's enrollment ceases for any reason.

(e) EVALUATION; REPORT.—

(1) EVALUATION.—The Secretary, using the criteria described in section 1866F(e)(1) of the So-

cial Security Act (as inserted by section 1123), shall conduct an evaluation of the pilot program under this section.

(2) REPORT.—Not later than 60 days after the date of completion of the evaluation under paragraph (1), the Secretary shall submit to Congress and make available to the public a report on the findings of the evaluation under such paragraph.

(f) FUNDING.—The additional Federal financial participation resulting from the implementation of the pilot program under this section may not exceed in the aggregate $1,235,000,000 over the 5-year period of the program.

SEC. 1723. TRANSLATION OR INTERPRETATION SERVICES.

(a) IN GENERAL.—Section 1903(a)(2)(E) of the Social Security Act (42 U.S.C. 1396b(a)(2)), as added by section 201(b)(2)(A) of the Children's Health Insurance Program Reauthorization Act of 2009 (Public Law 111–3), is amended by inserting ''and other individuals'' after ''children of families''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to payment for translation or interpretation services furnished on or after January 1, 2010.

SEC. 1724. OPTIONAL COVERAGE FOR FREESTANDING BIRTH CENTER SERVICES.

(a) IN GENERAL.—Section 1905 of the Social Security Act (42 U.S.C. 1396d), as amended by section 1713(a), is amended—

(1) in subsection (a)—

(A) by redesignating paragraph (29) as paragraph (30);

(B) in paragraph (28), by striking at the end ''and''; and

(C) by inserting after paragraph (28) the following new paragraph:

''(29) freestanding birth center services (as defined in subsection (l)(3)(A)) and other ambulatory services that are offered by a freestanding birth center (as defined in subsection (l)(3)(B)) and that are otherwise included in the plan; and''; and

(2) in subsection (l), by adding at the end the following new paragraph:

''(3)(A) The term 'freestanding birth center services' means services furnished to an individual at a freestanding birth center (as defined in subparagraph (B)), including by a licensed birth attendant (as defined in subparagraph (C)) at such center.

''(B) The term 'freestanding birth center' means a health facility—

''(i) that is not a hospital; and

''(ii) where childbirth is planned to occur away from the pregnant woman's residence.

''(C) The term 'licensed birth attendant' means an individual who is licensed or registered by the State involved to provide health care at childbirth and who provides such care within the scope of practice under which the individual is legally authorized to perform such care under State law (or the State regulatory mechanism provided by State law), regardless of whether the individual is under the supervision of, or associated with, a physician or other health care provider. Nothing in this subparagraph shall be construed as changing State law requirements applicable to a licensed birth attendant.''.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to items and services furnished on or after the date of the enactment of this Act.

SEC. 1725. INCLUSION OF PUBLIC HEALTH CLINICS UNDER THE VACCINES FOR CHILDREN PROGRAM.

Section 1928(b)(2)(A)(iii)(I) of the Social Security Act (42 U.S.C. 1396s(b)(2)(A)(iii)(I)) is amended—

(1) by striking ''or a rural health clinic'' and inserting '', a rural health clinic''; and

(2) by inserting ''or a public health clinic,'' after '`''1905(l)(1)),''.

SEC. 1726. REQUIRING COVERAGE OF SERVICES OF PODIATRISTS.

(a) IN GENERAL.—Section 1905(a)(5)(A) of the Social Security Act (42 U.S.C. 1396d(a)(5)(A)) is amended by striking ''section 1861(r)(1)'' and inserting ''paragraphs (1) and (3) of section 1861(r)''.

(b) EFFECTIVE DATE.—Except as provided in section 1790, the amendment made by subsection (a) shall apply to services furnished on or after January 1, 2010.

SEC. 1726A. REQUIRING COVERAGE OF SERVICES OF OPTOMETRISTS.

(a) IN GENERAL.—Section 1905(a)(5) of the Social Security Act (42 U.S.C. 1396d(a)(5)) is amended—

(1) by striking ''and'' before ''(B)''; and

(2) by inserting before the semicolon at the end the following: '', and (C) medical and other health services (as defined in section 1861(s)) as authorized by State law, furnished by an optometrist (described in section 1861(r)(4)) to the extent such services may be performed under State law''.

(b) EFFECTIVE DATE.—Except as provided in section 1790, the amendments made by subsection (a) shall take effect 90 days after the date of the enactment of this Act and shall apply to services furnished or other actions required on or after such date.

SEC. 1727. THERAPEUTIC FOSTER CARE.

(a) RULE OF CONSTRUCTION.—Nothing in this title shall prevent or limit a State from covering therapeutic foster care for eligible children in out-of-home placements under section 1905(a) of the Social Security Act (42 U.S.C. 1396d(a)).

(b) THERAPEUTIC FOSTER CARE DEFINED.—For purposes of this section, the term ''therapeutic foster care'' means a foster care program that provides—

(1) to the child—

(A) structured daily activities that develop, improve, monitor, and reinforce age-appropriate social, communications, and behavioral skills;

(B) crisis intervention and crisis support services;

(C) medication monitoring;

(D) counseling; and

(E) case management services; and

(2) specialized training for the foster parent and consultation with the foster parent on the management of children with mental illnesses and related health and developmental conditions.

SEC. 1728. ASSURING ADEQUATE PAYMENT LEVELS FOR SERVICES.

(a) IN GENERAL.—Title XIX of the Social Security Act is amended by inserting after section 1925 the following new section:

''ASSURING ADEQUATE PAYMENT LEVELS FOR SERVICES

''SEC. 1926. (a) IN GENERAL.—A State plan under this title shall not be considered to meet the requirement of section 1902(a)(30)(A) for a year (beginning with 2011) unless, by not later than April 1 before the beginning of such year, the State submits to the Secretary an amendment to the plan that specifies the payment rates to be used for such services under the plan in such year and includes in such submission such additional data as will assist the Secretary in evaluating the State's compliance with such requirement, including data relating to how rates established for payments to medicaid managed care organizations under sections 1903(m) and 1932 take into account such payment rates.

''(b) SECRETARIAL REVIEW.—The Secretary, by not later than 90 days after the date of submission of a plan amendment under subsection (a), shall—

''(1) review each such amendment for compliance with the requirement of section 1902(a)(30)(A); and

''(2) approve or disapprove each such amendment.

If the Secretary disapproves such an amendment, the State shall immediately submit a revised amendment that meets such requirement.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect on the date of the enactment of this Act.

SEC. 1729. PRESERVING MEDICAID COVERAGE FOR YOUTHS UPON RELEASE FROM PUBLIC INSTITUTIONS.

Section 1902(a) of the Social Security Act (42 U.S.C. 1396a), as amended by section 1631(b) and 1703(a), is amended—

(1) by striking ''and'' at the end of paragraph (74);

(2) by striking the period at the end of paragraph (75) and inserting ''; and''; and

(3) by inserting after paragraph (75) the following new paragraph:

''(76) provide that in the case of any youth who is 18 years of age or younger, was enrolled for medical assistance under the State plan immediately before becoming an inmate of a public institution, is 18 years of age or younger upon release from such

institution, and is eligible for such medical assistance under the State plan at the time of release from such institution—

''(A) during the period such youth is incarcerated in a public institution, the State shall not terminate eligibility for medical assistance under the State plan for such youth;

''(B) during the period such youth is incarcerated in a public institution, the State shall establish a process that ensures—

''(i) that the State does not claim federal financial participation for services that are provided to such youth and that are excluded under subsection 1905(a)(28)(A); and

''(ii) that the youth receives medical assistance for which federal participation is available under this title;

''(C) on or before the date such youth is released from such institution, the State shall ensure that such youth is enrolled for medical assistance under this title, unless and until there is a determination that the individual is no longer eligible to be so enrolled; and

''(D) the State shall ensure that enrollment under subparagraph (C) will be completed before such date so that the youth can access medical assistance under this title immediately upon leaving the institution.''

SEC. 1730. QUALITY MEASURES FOR MATERNITY AND ADULT HEALTH SERVICES UNDER MEDICAID AND CHIP.

Title XI of the Social Security Act (42 U.S.C. 1301 et seq.) is amended by inserting after section 1139A the following new section:

''SEC. 1139B. QUALITY MEASURES FOR MATERNITY AND ADULT HEALTH SERVICES UNDER MEDICAID AND CHIP.

''(a) MATERNITY CARE QUALITY MEASURES UNDER MEDICAID AND CHIP.—

''(1) DEVELOPMENT OF MEASURES.—No later than January 1, 2011, the Secretary shall develop and publish for comment a proposed set of measures that accurately describe the quality of maternity care provided under State plans under titles XIX and XXI. The Secretary shall publish a final recommended set of such measures no later than July 1, 2011.

''(2) STANDARDIZED REPORTING FORMAT.—No later than January 1, 2012, the Secretary shall develop and publish a standardized reporting format for maternity care quality measures for use by State programs under titles XIX and XXI to collect data from managed care entities and providers and practitioners that participate in such programs and to report maternity care quality measures to the Secretary.

''(b) OTHER ADULT HEALTH QUALITY MEASURES UNDER MEDICAID.—

''(1) DEVELOPMENT OF MEASURES.—The Secretary shall develop quality measures that are not otherwise developed under section 1192 for services received under State plans under title XIX by individuals who are 21 years of age or older but have not attained age 65. The Secretary shall publish such quality measures through notice and comment rulemaking.

''(2) STANDARDIZED REPORTING FORMAT.—The Secretary shall develop and publish a standardized reporting format for quality measures developed under paragraph (1) and section 1192 for services furnished under State plans under title XIX to individuals who are 21 years of age or older but have

not attained age 65 for use under such plans and State plans under title XXI. The format shall enable State agencies administering such plans to collect data from managed care entities and providers and practitioners that participate in such plans and to report quality measures to the Secretary.

''(c) DEVELOPMENT PROCESS.—With respect to the development of quality measures under subsections (a) and (b)—

''(1) USE OF QUALIFIED ENTITIES.—The Secretary may enter into agreements with public, nonprofit, or academic institutions with technical expertise in the area of health quality measurement to assist in such development. The Secretary may carry out these agreements by contract, grant, or otherwise.

''(2) MULTI-STAKEHOLDER PRE-RULEMAKING INPUT.—The Secretary shall obtain the input of stakeholders with respect to such quality measures using a process similar to that described in section 1808(d).

''(3) COORDINATION.—The Secretary shall coordinate the development of such measures under such subsections and with the development of child health quality measures under section 1139A.

''(d) ANNUAL REPORT TO CONGRESS.—No later than January 1, 2013, and annually thereafter, the Secretary shall report to the Committee on Energy and Commerce of the House of Representatives the Committee on Finance of the Senate regarding—

''(1) the availability of reliable data relating to the quality of maternity care furnished under State plans under titles XIX and XXI;

''(2) the availability of reliable data relating to the quality of services furnished under State plans under title XIX to adults who are 21 years of age or older but have not attained age 65; and

''(3) recommendations for improving the quality of such care and services furnished under such State plans.

''(e) RULE OF CONSTRUCTION.—Notwithstanding any other provision in this section, no quality measure developed, published, or used as a basis of measurement or reporting under this section may be used to establish an irrebuttable presumption regarding either the medical necessity of care or the maximum permissible coverage for any individual who receives medical assistance under title XIX or child health assistance under title XXI.

''(f) APPROPRIATION.—For purposes of carrying out this section, in addition to funds otherwise available, out

of any funds in the Treasury not otherwise appropriated, there are appropriated $40,000,000 for the 5-fiscal-year period beginning with fiscal year 2010. Funds appropriated under this subsection shall remain available until expended.''.

SEC. 1730A. ACCOUNTABLE CARE ORGANIZATION PILOT PROGRAM.

(a) IN GENERAL.—The Secretary of Health and Human Services shall establish under this section an accountable care program under which a State may apply to the Secretary for approval of an accountable care organization pilot program described in subsection (b) (in this section referred to as a ''pilot program'') for the application of the accountable care organization concept under title XIX of the Social Security Act.

(b) PILOT PROGRAM DESCRIBED.—

(1) IN GENERAL.—The pilot program described in this subsection is a program that applies one or more of the accountable care organization models described in section 1866E of the Social Security Act, as added by section 1301 of this Act.

(2) LIMITATION.—The pilot program shall operate for a period of not more than 5 years.

(c) ADDITIONAL INCENTIVES.—In the case of the pilot program under this section, the Secretary may—

(1) waive the requirements of—

(A) section 1902(a)(1) of the Social Security Act (relating to statewideness);

(B) section 1902(a)(10)(B) of such Act (relating to comparability); and

(2) increase the matching percentage for administrative expenditures up to—

(A) 90 percent (for the first 2 years of the pilot program); and

(B) 75 percent (for the next 3 years).

(d) EVALUATION; REPORT.—

(1) EVALUATION.—The Secretary shall conduct an evaluation of the pilot program under this section. In conducting such evaluation, the Secretary shall use the criteria used under subsection (g)(1) of section 1866E of the Social Security Act (as inserted by section 1301 of this Act) to evaluate pilot programs under such section.

(2) REPORT.—Not later than 60 days after the date of completion of the evaluation under paragraph (1), the Secretary shall submit to Congress and make available to the public a report on the findings of the evaluation under such paragraph.

SEC. 1730B. FQHC COVERAGE.

Section 1905(l)(2)(B) of the Social Security Act (42 U.S.C. 1396d(l)(2)(B)) is amended—

(1) by striking ''or'' at the end of clause (iii);

(2) by striking the semicolon at the end of clause (iv) and inserting '', and''; and

(3) by inserting after clause (iv) the following new clause:

''(v) is receiving a grant under section 399Z–1 of the Public Health Service Act;''.

Subtitle D—Coverage

SEC. 1731. OPTIONAL MEDICAID COVERAGE OF LOW-INCOME HIV-INFECTED INDIVIDUALS.

(a) IN GENERAL.— Section 1902 of the Social Security Act (42 U.S.C. 1396a), as amended by section 1714(a)(1), is amended—

(1) in subsection (a)(10)(A)(ii)—

(A) by striking ''or'' at the end of subclause (XIX);

(B) by adding ''or'' at the end of subclause (XX); and

(C) by adding at the end the following:

''(XXI) who are described in subsection (ii) (relating to HIV-infected individuals);''; and

(2) by adding at the end, as amended by sections 1703 and 1714(a), the following:

''(ii) Individuals described in this subsection are individuals not described in subsection (a)(10)(A)(i)—

''(1) who have HIV infection;

''(2) whose income (as determined under the State plan under this title with respect to disabled individuals) does not exceed the maximum amount of income a disabled individual described in subsection (a)(10)(A)(i) may have and obtain medical assistance under the plan; and

''(3) whose resources (as determined under the State plan under this title with respect to disabled individuals) do not exceed the maximum amount of resources a disabled individual described in subsection (a)(10)(A)(i) may have and obtain medical assistance under the plan.''.

(b) ENHANCED MATCH.—The first sentence of section 1905(b) of such Act (42 U.S.C. 1396d(b)) is amended by striking ''section 1902(a)(10)(A)(ii)(XVIII)'' and inserting ''subclause (XVIII) or (XXI) of section 1902(a)(10)(A)(ii)''.

(c) CONFORMING AMENDMENTS.—Section 1905(a) of such Act (42 U.S.C. 1396d(a)) is amended, in the matter preceding paragraph (1)—

(1) by striking ''or'' at the end of clause (xii);

(2) by adding ''or'' at the end of clause (xiii); and

(3) by inserting after clause (xiii) the following:

''(xiv) individuals described in section 1902(ii),''.

(d) EXEMPTION FROM FUNDING LIMITATION FOR TERRITORIES.—Section 1108(g) of the Social Security Act (42 U.S.C. 1308(g)) is amended by adding at the end the following:

''(5) DISREGARDING MEDICAL ASSISTANCE FOR OPTIONAL LOW-INCOME HIV-INFECTED INDIVIDUALS.—The limitations under subsection (f) and the previous provisions of this subsection shall not apply to amounts expended for medical assistance for individuals described in section 1902(ii) who are only eligible for such assistance on the basis of section 1902(a)(10)(A)(ii)(XXI).''.

(e) EFFECTIVE DATE; SUNSET.—The amendments made by this section shall apply to expenditures for calendar quarters beginning on or after the date of the enactment of this Act, and before January 1, 2013, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.

SEC. 1732. EXTENDING TRANSITIONAL MEDICAID ASSISTANCE (TMA).

Sections 1902(e)(1)(B) and 1925(f) of the Social Security Act (42 U.S.C. 1396a(e)(1)(B), 1396r–6(f)), as amended by section 5004(a)(1) of the American Recovery and Reinvestment Act of 2009 (Public Law 111–5), are each amended by striking ''December 31, 2010'' and inserting ''December 31, 2012''.

SEC. 1733. REQUIREMENT OF 12-MONTH CONTINUOUS COVERAGE UNDER CERTAIN CHIP PROGRAMS.

(a) IN GENERAL.—Section 2102(b) of the Social Security Act (42 U.S.C. 1397bb(b)) is amended by adding at the end the following new paragraph:

''(6) REQUIREMENT FOR 12-MONTH CONTINUOUS ELIGIBILITY.—In the case of a State child health plan that provides child health assistance under this title through a means other than described in section 2101(a)(2), the plan shall provide for implementation under this title of the 12-month continuous eligibility option described in section 1902(e)(12) for targeted low-income children whose family income is below 200 percent of the poverty line.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to determinations (and redeterminations) of eligibility made on or after January 1, 2010.

SEC. 1734. PREVENTING THE APPLICATION UNDER CHIP OF COVERAGE WAITING PERIODS FOR CERTAIN CHILDREN.

(a) IN GENERAL.—Section 2102(b)(1) of the Social Security Act (42 U.S.C. 1397bb(b)(1)) is amended—

(1) in subparagraph (B)—

(A) in clause (iii), by striking ''and'' at the end;

(B) in clause (iv), by striking the period at the end and inserting ''; and''; and

(C) by adding at the end the following new clause:

''(v) may not apply a waiting period (including a waiting period to carry out paragraph (3)(C)) in the case of a child described in subparagraph (C).''; and

(2) by adding at the end the following new subparagraph:

''(C) DESCRIPTION OF CHILDREN NOT SUBJECT TO WAITING PERIOD.—For purposes of this paragraph, a child described in this subparagraph is a child who, on the date an application is submitted for such child for child health assistance under this title, meets any of the following requirements:

''(i) INFANTS AND TODDLERS.—The child is under two years of age.

''(ii) LOSS OF GROUP HEALTH PLAN COVERAGE.—The child previously had private health insurance coverage through a group health plan or health insurance coverage offered through an employer and lost such coverage due to—

''(I) termination of an individual's employment;

''(II) a reduction in hours that an individual works for an employer;

''(III) elimination of an individual's retiree health benefits; or

''(IV) termination of an individual's group health plan or health insurance coverage offered through an employer.

''(iii) UNAFFORDABLE PRIVATE COVERAGE.—

''(I) IN GENERAL.—The family of the child demonstrates that the cost of health insurance coverage (including the cost of premiums, co-payments, deductibles, and other cost

sharing) for such family exceeds 10 percent of the income of such family.

''(II) DETERMINATION OF FAMILY INCOME.—For purposes of subclause (I), family income shall be determined in the same manner specified by the State for purposes of determining a child's eligibility for child health assistance under this title.''.

(b) EFFECTIVE DATE.—The amendments made by this section shall take effect as of the date that is 90 days after the date of the enactment of this Act.

SEC. 1735. ADULT DAY HEALTH CARE SERVICES.

(a) IN GENERAL.—The Secretary of Health and Human Services shall not—

(1) withhold, suspend, disallow, or otherwise deny Federal financial participation under section 1903(a) of the Social Security Act (42 U.S.C. 1396b(a)) for the provision of adult day health care services, day activity and health services, or adult medical day care services, as defined under a State Medicaid plan approved during or before 1994, during such period if such services are provided consistent with such definition and the requirements of such plan; or

(2) withdraw Federal approval of any such State plan or part thereof regarding the provision of such services (by regulation or otherwise).

(b) EFFECTIVE DATE.—Subsection (a) shall apply with respect to services provided on or after October 1, 2008.

SEC. 1736. MEDICAID COVERAGE FOR CITIZENS OF FREELY ASSOCIATED STATES.

(a) IN GENERAL.—Section 402(b)(2) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1612(b)(2)) is amended by adding at the end the following:

''(G) MEDICAID EXCEPTION FOR CITIZENS OF FREELY ASSOCIATED STATES.—With respect to eligibility for benefits for the designated Federal program defined in paragraph (3)(C) (relating to the Medicaid program), section 401(a) and paragraph (1) shall not apply to any individual who lawfully resides in 1 of the 50 States or the District of Columbia in accordance with the Compacts of Free Association between the Government of the United States and the Governments of the Federated States of Micronesia, the Republic of the Marshall Islands, and the Republic of Palau.''.

(b) EXCEPTION TO 5-YEAR LIMITED ELIGIBILITY.—Section 403(d) of such Act (8 U.S.C. 1613(d)) is amended—

(1) in paragraph (1), by striking ''or'' at the end;

(2) in paragraph (2), by striking the period at the end and inserting ''; or''; and

(3) by adding at the end the following:

''(3) an individual described in section 402(b)(2)(G), but only with respect to the designated Federal program defined in section 402(b)(3)(C).''.

(c) DEFINITION OF QUALIFIED ALIEN.—Section 431(b) of such Act (8 U.S.C. 1641(b)) is amended—

(1) in paragraph (6), by striking ''; or'' at the end and inserting a comma;

(2) in paragraph (7), by striking the period at the end and inserting '', or''; and

(3) by adding at the end the following:

''(8) an individual who lawfully resides in the United States in accordance with a Compact of Free Association referred to in section 402(b)(2)(G), but only with respect to the designated Federal program defined in section 402(b)(3)(C) (relating to the Medicaid program).''.

SEC. 1737. CONTINUING REQUIREMENT OF MEDICAID COVERAGE OF NONEMERGENCY TRANSPORTATION TO MEDICALLY NECESSARY SERVICES.

(a) REQUIREMENT.—Section 1902(a)(10) of the Social Security Act (42 U.S.C. 1396a(a)(10)) is amended—

(1) in subparagraph (A), in the matter preceding clause (i), by striking ''and (21)'' and inserting '', (21), and (30)''; and

(2) in subparagraph (C)(iv), by striking ''and (17)'' and inserting '', (17), and (30)''.

(b) DESCRIPTION OF SERVICES.—Section 1905(a) of such Act (42 U.S.C. 1395d(a)), as amended by sections 1713(a)(1) and 1724(a)(1), is amended—

(1) in paragraph (29), by striking ''and'' at the end;

(2) by redesignating paragraph (30) as paragraph (31) and by striking the comma at the end and inserting a semicolon; and

(3) by inserting after paragraph (29) the following new paragraph:

''(30) nonemergency transportation to medically necessary services, consistent with the requirement of section 431.53 of title 42, Code of Federal Regulations, as in effect as of June 1, 2008; and''.

(c) EFFECTIVE DATE.—The amendments made by this section shall take effect on the date of the enactment of this Act and shall apply to transportation on or after such date.

SEC. 1738. STATE OPTION TO DISREGARD CERTAIN INCOME IN PROVIDING CONTINUED MEDICAID COVERAGE FOR CERTAIN INDIVIDUALS WITH EXTREMELY HIGH PRESCRIPTION COSTS.

Section 1902(e) of the Social Security Act (42 U.S.C. 1396b(e)), as amended by section 203(a) of the Children's Health Insurance Program Reauthorization Act of 2009 (Public Law 111–3), is amended by adding at the end the following new paragraph:

''(14)(A) At the option of the State, in the case of an individual with extremely high prescription drug costs described in subparagraph (B) who has been determined (without the application of this paragraph) to be eligible for medical assistance under this title, the State may, in redetermining the individual's eligibility for medical assistance under this title, disregard any family income of the individual to the extent such income is less than an amount that is specified by the State and does not exceed the amount specified in subparagraph (C), or, if greater, income equal to the cost of the orphan drugs described in subparagraph (B)(iii).

''(B) An individual with extremely high prescription drug costs described in this subparagraph for a 12-month period is an individual—

''(i) who is covered under health insurance or a health benefits plan that has a maximum lifetime limit of not less than $1,000,000 which includes all prescription drug coverage;

''(ii) who has exhausted all available prescription drug coverage under the plan as of the beginning of such period;

''(iii) who incurs (or is reasonably expected to incur) on an annual basis during the period costs for orphan drugs in excess of the amount specified in subparagraph (C) for the period; and

''(iv) whose annual family income (determined without regard to this paragraph) as of the beginning of the period does not exceed 75 percent of the amount incurred for such drugs (as described in clause (iii)).

''(C) The amount specified in this subparagraph for a 12-month period beginning in—

''(i) 2009 or 2010, is $200,000; or

''(ii) a subsequent year, is the amount specified in clause (i) (or this subparagraph) for the previous year increased by the annual rate of increase in the

medical care component of the consumer price index (U.S. city average) for the 12-month period ending in August of the previous year.

Any amount computed under clause (ii) that is not a multiple of $1,000 shall be rounded to the nearest multiple of $1,000.

''(D) In applying this paragraph, amounts incurred for prescription drugs for cosmetic purposes shall not be taken into account.

''(E) With respect to an individual described in subparagraph (A), notwithstanding section 1916, the State plan—

''(i) shall provide for the application of cost-sharing that is at least nominal as determined under section 1916; and

''(ii) may provide, consistent with section 1916A, for such additional cost-sharing as does not exceed a maximum level of cost-sharing that is specified by the Secretary and is adjusted by the Secretary on an annual basis.

''(F) A State electing the option under this paragraph shall provide for a determination on an individual's application for continued medical assistance under this title within 30 days of the date the application if filed with the State.

''(G) In this paragraph:

''(i) The term 'orphan drugs' means prescription drugs designated under section 526 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360bb) as a drug for a rare disease or condition.

''(ii) The term 'health benefits plan' includes coverage under a plan offered under a State high risk pool.''.

SEC. 1739. PROVISIONS RELATING TO COMMUNITY LIVING ASSISTANCE SERVICES AND SUPPORTS (CLASS).

(a) COORDINATION WITH CLASS PROVISIONS.—Section 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)), as amended by sections 1631(b), 1703(a), 1729, 1753, 1757(a), 1759(a), 1783(a), and 1907(b), is amended—

(1) in paragraph (80), by striking ''and'' at the end;

(2) in paragraph (81), by striking the period and inserting ''; and''; and

(3) by inserting after paragraph (81) the following:

''(82) provide that the State will comply with such regulations regarding the application of primary and secondary payor rules with respect to indi-

viduals who are eligible for medical assistance under this title and are eligible beneficiaries under the CLASS program established under title XXXII of the Public Health Service Act as the Secretary shall establish.''.

(b) ASSURANCE OF ADEQUATE INFRASTRUCTURE FOR THE PROVISION OF PERSONAL CARE ATTENDANT WORKERS.—Section 1902(a) of such Act (42 U.S.C. 1396a(a)), as amended by subsection (a), is amended—

(1) in paragraph (81), by striking ''and'' at the end;

(2) in paragraph (82), by striking the period at the end and inserting ''; and''; and

(3) by inserting after paragraph (82), the following:

''(83) provide that, not later than 2 years after the date of enactment of this paragraph, each State shall—

''(A) assess the extent to which entities such as providers of home care, home health services, home and community service providers, public authorities created to provide personal care services to individuals eligible for medical assistance under the State plan, and nonprofit organizations, are serving or have the capacity

to serve as fiscal agents for, employers of, and providers of employment-related benefits for, personal care attendant workers who provide personal care services to individuals receiving benefits under the CLASS program established under title XXXII of the Public Health Service Act, including in rural and underserved areas;

''(B) designate or create such entities to serve as fiscal agents for, employers of, and providers of employment-related benefits for, such workers to ensure an adequate supply of the workers for individuals receiving benefits under the CLASS program, including in rural and underserved areas; and

''(C) ensure that the designation or creation of such entities will not negatively alter or impede existing programs, models, methods, or administration of service delivery that provide for consumer controlled or self-directed home and community services and further ensure that such entities will not impede the ability of individuals to direct and control their home and community services, including the ability to select, manage, dismiss, co-employ, or employ such workers or inhibit such individuals from

relying on family members for the provision of personal care services.''.

(c) INCLUSION OF INFORMATION ON SUPPLEMENTAL COVERAGE IN THE NATIONAL CLEARINGHOUSE FOR LONG-TERM CARE INFORMATION; EXTENSION OF FUNDING.—Section 6021(d) of the Deficit Reduction Act of 2005 (42 U.S.C. 1396p note) is amended—

(1) in paragraph (2)(A)—

(A) in clause (ii), by striking ''and'' at the end;

(B) in clause (iii), by striking the period at the end and inserting ''; and''; and

(C) by adding at the end the following:

''(iv) include information regarding the CLASS program established under title XXXII of the Public Health Service Act.''; and

(2) in paragraph (3)—

(A) by striking ''2010'' and inserting ''2015''; and

(B) by adding at the end the following: ''In addition to the amount appropriated under the previous sentence, there are authorized to be appropriated to carry out this subsection,

$7,000,000 for each of fiscal years 2011, 2012, and 2013.''.

(d) EFFECTIVE DATE.—The amendments made by this section take effect on January 1, 2011.

Subtitle E—Financing

SEC. 1741. PAYMENTS TO PHARMACISTS.

(a) PHARMACY REIMBURSEMENT LIMITS.—

(1) IN GENERAL.—Section 1927(e) of the Social Security Act (42 U.S.C. 1396r–8(e)) is amended—

(A) by striking paragraph (5) and inserting the following:

''(5) USE OF AMP IN UPPER PAYMENT LIMITS.—The Secretary shall calculate the Federal upper reimbursement limit established under paragraph (4) as 130 percent of the weighted average (determined on the basis of manufacturer utilization) of monthly average manufacturer prices. Nothing in the previous sentence shall be construed as preventing the Secretary from performing such calculation using a smoothing process in order to reduce significant variations from month to month as a result of rebates, discounts, and other pricing practices, such as in the manner such a process is used by the Secretary in determining the average

sales price of a drug or biological under section 1847A.''

(2) DEFINITION OF AMP.—Section 1927(k)(1)(B) of such Act (42 U.S.C. 1396r–8(k)(1)(B)) is amended—

(B) in the heading, by striking ''EXTENDED TO WHOLESALERS'' and inserting ''AND OTHER PAYMENTS''; and

(C) by striking ''regard to'' and all that follows through the period and inserting the following: ''regard to—

''(i) customary prompt pay discounts extended to wholesalers;

''(ii) bona fide service fees paid by manufacturers;

''(iii) reimbursement by manufacturers for recalled, damaged, expired, or otherwise unsalable returned goods, including reimbursement for the cost of the goods and any reimbursement of costs associated with return goods handling and processing, reverse logistics, and drug destruction;

''(iv) sales directly to, or rebates, discounts, or other price concessions provided to, pharmacy benefit managers, managed

care organizations, health maintenance organizations, insurers, mail order pharmacies that are not open to all members of the public, or long term care providers, provided that these rebates, discounts, or price concessions are not passed through to retail pharmacies;

''(v) sales directly to, or rebates, discounts, or other price concessions provided to, hospitals, clinics, and physicians, unless the drug is an inhalation, infusion, or injectable drug, or unless the Secretary determines, as allowed for in Agency administrative procedures, that it is necessary to include such sales, rebates, discounts, and price concessions in order to obtain an accurate AMP for the drug. Such a determination shall not be subject to judicial review; or

''(vi) rebates, discounts, and other price concessions required to be provided under agreements under subsections (f) and (g) of section 1860D–2(f).''.

(3) MANUFACTURER REPORTING REQUIREMENTS.—Section 1927(b)(3)(A) of such Act (42 U.S.C. 1396r–8(b)(3)(A)) is amended—

(A) in clause (ii), by striking ''and'' at the end;

(B) by striking the period at the end of clause (iii) and inserting ''; and''; and

(C) by inserting after clause (iii) the following new clause:

''(iv) not later than 30 days after the last day of each month of a rebate period under the agreement, on the manufacturer's total number of units that are used to calculate the monthly average manufacturer price for each covered outpatient drug.''.

(4) AUTHORITY TO PROMULGATE REGULATION.—The Secretary of Health and Human Services may promulgate regulations to clarify the requirements for upper payment limits and for the determination of the average manufacturer price in an expedited manner. Such regulations may become effective on an interim final basis, pending opportunity for public comment.

(5) PHARMACY REIMBURSEMENTS THROUGH DECEMBER 31, 2010.—The specific upper limit under section 447.332 of title 42, Code of Federal Regulations (as in effect on December 31, 2006) applicable to payments made by a State for multiple source drugs under a State Medicaid plan shall continue to apply through December 31, 2010, for purposes of the availability of Federal financial participation for such payments.

(b) DISCLOSURE OF PRICE INFORMATION TO THE PUBLIC.—Section 1927(b)(3) of such Act (42 U.S.C. 1396r–8(b)(3)) is amended—

(1) in subparagraph (A)—

(A) in clause (i), in the matter preceding subclause (I), by inserting ''month of a'' after ''each''; and

(B) in the last sentence, by striking ''and shall,'' and all that follows up to the period; and

(2) in subparagraph (D)(v), by inserting ''weighted'' before ''average manufacturer prices''.

SEC. 1742. PRESCRIPTION DRUG REBATES.

(a) ADDITIONAL REBATE FOR NEW FORMULATIONS OF EXISTING DRUGS.—

(1) IN GENERAL.—Section 1927(c)(2) of the Social Security Act (42 U.S.C. 1396r–8(c)(2)) is amended by adding at the end the following new subparagraph:

''(C) TREATMENT OF NEW FORMULATIONS.—In the case of a drug that is a line extension of a single source drug or an innovator multiple source drug that is an oral solid dosage form, the rebate obligation with respect to such drug under this section shall be the amount computed under this section for such new drug or, if greater, the product of—

''(i) the average manufacturer price of the line extension of a single source drug or an innovator multiple source drug that is an oral solid dosage form;

''(ii) the highest additional rebate (calculated as a percentage of average manufacturer price) under this section for any strength of the original single source drug or innovator multiple source drug; and

''(iii) the total number of units of each dosage form and strength of the line extension product paid for under the State

plan in the rebate period (as reported by the State).

In this subparagraph, the term 'line extension' means, with respect to a drug, a new formulation of the drug, such as an extended release formulation.''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to drugs dispensed after December 31, 2009.

(b) INCREASE MINIMUM REBATE PERCENTAGE FOR SINGLE SOURCE DRUGS.—

(1) IN GENERAL.—Section 1927(c)(1)(B)(i) of the Social Security Act (42 U.S.C. 1396r–8(c)(1)(B)(i)) is amended—

(A) in subclause (IV), by striking ''and'' at the end;

(B) in subclause (V)—

(i) by inserting ''and before January 1, 2010'' after ''December 31, 1995,''; and

(ii) by striking the period at the end and inserting ''; and''; and

(C) by adding at the end the following new subclause:

''(VI) after December 31, 2009, is 23.1 percent.''.

(2) RECAPTURE OF TOTAL SAVINGS DUE TO INCREASE.—Section 1927(b)(1) of such Act is amended by adding at the end the following new subparagraph:

''(C) SPECIAL RULE FOR INCREASED MINIMUM REBATE PERCENTAGE.—

''(i) IN GENERAL.—In addition to the amounts applied as a reduction under subparagraph (B), for rebate periods beginning on or after January 1, 2010, during a fiscal year, the Secretary shall reduce payments to a State under section 1903(a) in the manner specified in clause (ii), in an amount equal to the product of—

''(I) 100 percent minus the Federal medical assistance percentage applicable to the rebate period for the State; and

''(II) the amounts received by the State under such subparagraph that are attributable (as estimated by the Secretary based on utilization and other data) to the increase in the minimum rebate percentage effected by the amendments made by section

1742(b)(1) of the Affordable Health Care for America Act, taking into account the additional drugs included under the amendments made by section 1743 of such Act.

The Secretary shall adjust such payment reduction for a calendar quarter to the extent the Secretary determines, based upon subsequent utilization and other data, that the reduction for such quarter was greater or less than the amount of payment reduction that should have been made.

''(ii) MANNER OF PAYMENT REDUCTION.—The amount of the payment reduction under clause (i) for a State for a quarter shall be deemed an overpayment to the State under this title to be disallowed against the State's regular quarterly draw for all Medicaid spending under section 1903(d)(2). Such a disallowance is not subject to a reconsideration under 1116(d).''.

SEC. 1743. EXTENSION OF PRESCRIPTION DRUG DISCOUNTS TO ENROLLEES OF MEDICAID MANAGED CARE ORGANIZATIONS.

(a) IN GENERAL.—Section 1903(m)(2)(A) of the Social Security Act (42 U.S.C. 1396b(m)(2)(A)) is amended—

(1) in clause (xi), by striking ''and'' at the end;

(2) in clause (xii), by striking the period at the end and inserting ''; and''; and

(3) by adding at the end the following:

''(xiii) such contract provides that the entity shall report to the State such information, on such timely and periodic basis as specified by the Secretary, as the State may require in order to include, in the information submitted by the State to a manufacturer under section 1927(b)(2)(A) and to the Secretary under section 1927(b)(2)(C), information on covered outpatient drugs dispensed to individuals eligible for medical assistance who are enrolled with the entity and for which the entity is responsible for coverage of such drugs under this subsection.''.

(b) CONFORMING AMENDMENTS.—Section 1927 of such Act (42 U.S.C. 1396r-8) is amended——

(1) in the first sentence of subsection (b)(1)(A), by inserting before the period at the end the following: '', including such drugs dispensed to individ-

uals enrolled with a medicaid managed care organization if the organization is responsible for coverage of such drugs'';

(2) in subsection (b)(2), by adding at the end the following new subparagraph:

''(C) REPORTING ON MMCO DRUGS.—On a quarterly basis, each State shall report to the Secretary the total amount of rebates in dollars received from pharmacy manufacturers for drugs provided to individuals enrolled with Medicaid managed care organizations that contract under section 1903(m) and such other information as the Secretary may require to carry out paragraph (1)(C) with respect to such rebates.''; and

(3) in subsection (j)—

(A) in the heading by striking ''EXEMPTION'' and inserting ''SPECIAL RULES''; and

(B) in paragraph (1), by striking ''are not subject to the requirements of this section'' and inserting ''are subject to the requirements of this section unless such drugs are subject to discounts under section 340B of the Public Health Service Act''.

(c) EFFECTIVE DATE.—The amendments made by this section take effect on January 1, 2010, and shall apply to drugs dispensed on or after such date, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.

SEC. 1744. PAYMENTS FOR GRADUATE MEDICAL EDUCATION.

(a) IN GENERAL.—Section 1905 of the Social Security Act (42 U.S.C. 1396d), as amended by sections 1701(a)(3)(B), 1711(a), and 1713(a), is amended by adding at the end the following new subsection:

''(bb) PAYMENT FOR GRADUATE MEDICAL EDUCATION.—

''(1) IN GENERAL.—The term 'medical assistance' includes payment for costs of graduate medical education consistent with this subsection, whether provided in or outside of a hospital.

''(2) SUBMISSION OF INFORMATION.—For purposes of paragraph (1) and section 1902(a)(13)(A)(v), payment for such costs is not consistent with this subsection unless—

''(A) the State submits to the Secretary, in a timely manner and on an annual basis specified by the Secretary, information on total payments for graduate medical education and how

such payments are being used for graduate medical education, including—

''(i) the institutions and programs eligible for receiving the funding;

''(ii) the manner in which such payments are calculated;

''(iii) the types and fields of education being supported;

''(iv) the workforce or other goals to which the funding is being applied;

''(v) State progress in meeting such goals; and

''(vi) such other information as the Secretary determines will assist in carrying out paragraphs (3) and (4); and

''(B) such expenditures are made consistent with such goals and requirements as are established under paragraph (4).

''(3) REVIEW OF INFORMATION.—The Secretary shall make the information submitted under paragraph (2) available to the Advisory Committee on Health Workforce Evaluation and Assessment (established under section 2261 of the Public Health Service Act). The Secretary and the Advisory Committee shall independently review the information

submitted under paragraph (2), taking into account State and local workforce needs.

''(4) SPECIFICATION OF GOALS AND REQUIREMENTS.—The Secretary shall specify by rule, initially published by not later than December 31, 2011—

''(A) program goals for the use of funds described in paragraph (1), taking into account recommendations of the such Advisory Committee and the goals for approved medical residency training programs described in section 1886(h)(1)(B); and

''(B) requirements for use of such funds consistent with such goals.

Such rule may be effective on an interim basis pending revision after an opportunity for public comment.''.

(b) CONFORMING AMENDMENT.—Section 1902(a)(13)(A) of such Act (42 U.S.C. 1396a(a)(13)(A)), as amended by section 1721(a)(1)(A), is amended—

(1) by striking ''and'' at the end of clause (iii);

(2) by striking the semicolon in clause (iv) and inserting '', and''; and

(3) by adding at the end the following new clause:

''(v) in the case of hospitals and at the option of a State, such rates may include, to the extent consistent with section 1905(bb), payment for graduate medical education; and''.

(c) EFFECTIVE DATE.—The amendments made by this section shall take effect on the date of the enactment of this Act. Nothing in this section shall be construed as affecting payments made before such date under a State plan under title XIX of the Social Security Act for graduate medical education.

SEC. 1745. NURSING FACILITY SUPPLEMENTAL PAYMENT PROGRAM.

(a) TOTAL AMOUNT AVAILABLE FOR PAYMENTS.—

(1) IN GENERAL.—Out of any funds in the Treasury not otherwise appropriated, there are appropriated to the Secretary of Health and Human Services (in this section referred to as the ''Secretary'') to carry out this section $6,000,000,000, of which the following amounts shall be available for obligation in the following years:

(A) $1,500,000,000 shall be available beginning in 2010.

(B) $1,500,000,000 shall be available beginning in 2011.

(C) $1,500,000,000 shall be available beginning in 2012.

(D) $1,500,000,000 shall be available beginning in 2013.

(2) AVAILABILITY.—Funds appropriated under paragraph (1) shall remain available until all eligible dually-certified facilities (as defined in subsection (b)(3)) have been reimbursed for underpayments under this section during cost reporting periods ending during calendar years 2010 through 2013.

(3) LIMITATION OF AUTHORITY.—The Secretary may not may payments under this section that exceed the funds appropriated under paragraph (1).

(4) DISPOSITION OF REMAINING FUNDS INTO MIF.—Any funds appropriated under paragraph (1) which remain available after the application of paragraph (2) shall be deposited into the Medicaid Improvement Fund under section 1941 of the Social Security Act.

(b) USE OF FUNDS.—

(1) AUTHORITY TO MAKE PAYMENTS.—From the amounts available for obligation in a year under subsection (a), the Secretary, acting through the Administrator of the Centers for Medicare & Medicaid

Services, shall pay the amount determined under paragraph (2) directly to an eligible dually-certified facility for the purpose of providing funding to reimburse such facility for furnishing quality care to Medicaid-eligible individuals.

(2) DETERMINATION OF PAYMENT AMOUNTS.—

(A) IN GENERAL.—Subject to subparagraphs (B) and (C), the payment amount determined under this paragraph for a year for an eligible dually-certified facility shall be an amount determined by the Secretary as reported on the facility's latest available Medicare cost report.

(B) LIMITATION ON PAYMENT AMOUNT.—In no case shall the payment amount for an eligible dually-certified facility for a year under subparagraph (A) be more than the payment deficit described in paragraph (3)(D) for such facility as reported on the facility's latest available Medicare cost report.

(C) PRO-RATA REDUCTION.—If the amount available for obligation under subsection (a) for a year (as reduced by allowable administrative costs under this section) is insufficient to ensure that each eligible dually-cer-

tified facility receives the amount of payment calculated under subparagraph (A), the Secretary shall reduce that amount of payment with respect to each such facility in a pro-rata manner to ensure that the entire amount available for such payments for the year be paid.

(D) NO REQUIRED MATCH.—The Secretary may not require that a State provide matching funds for any payment made under this subsection.

(3) ELIGIBLE DUALLY-CERTIFIED FACILITY DEFINED.—For purposes of this section, the term ''eligible dually-certified facility'' means, for a cost reporting period ending during a year (beginning no earlier than 2010) that is covered by the latest available Medicare cost report, a nursing facility that meets all of the following requirements:

(A) The facility is participating as a nursing facility under title XIX of the Social Security Act and as a skilled nursing facility under title XVIII of such Act during the entire year.

(B) The base Medicaid payment rate (excluding any supplemental payments) to the facility is not less than the base Medicaid pay-

ment rate (excluding any supplemental payments) to such facility as of June 16, 2009.

(C) As reported on the facility's latest Medicare cost report—

(i) the Medicaid share of patient days for such facility is not less than 60 percent of the combined Medicare and Medicaid share of resident days for such facility; and

(ii) the combined Medicare and Medicaid share of resident days for such facility, as reported on the facility's latest available Medicare cost report, is not less than 75 percent of the total resident days for such facility.

(D) The facility has received Medicaid reimbursement (including any supplemental payments) for the provision of covered services to Medicaid eligible individuals, as reported on the facility's latest available Medicare cost report, that is significantly less (as determined by the Secretary) than the allowable costs (as determined by the Secretary) incurred by the facility in providing such services.

(E) The facility is not in the highest quartile of costs costs per day, as determined by the

Secretary and as adjusted for case mix, wages, and type of facility.

(F) The facility provides quality care, as determined by the Secretary, to—

(i) Medicaid eligible individuals; and

(ii) individuals who are entitled to items and services under part A of title XVIII of the Social Security Act.

(G) In the most recent standard survey available, the facility was not cited for any immediate jeopardy deficiencies as defined by the Secretary.

(H) In the most recent standard survey available, the facility maintains an appropriate staffing level to attain or maintain the highest practicable well-being of each resident as defined by the Secretary

(I) The facility complies with all the requirements, as determined by the Secretary, contained in sections 1411 through 1416 and the amendments made by such sections.

(J) The facility was not listed as a Centers for Medicare & Medicaid Services Special Focus Facility (SFF) nor as a SFF on a State-based list.

(4) FREQUENCY OF PAYMENT.—Payment of an amount under this subsection to an eligible dually-certified facility shall be made for a year in a lump sum or in such periodic payments in such frequency as the Secretary determines appropriate.

(5) DIRECT PAYMENTS.—Such payment—

(A) shall be made directly by the Secretary to an eligible dually-certified facility or a contractor designated by such facility; and

(B) shall not be made through a State.

(c) ADMINISTRATION.—

(1) ANNUAL APPLICATIONS; DEADLINES.—The Secretary shall establish a process, including deadlines, under which facilities may apply on an annual basis to qualify as eligible dually-certified facilities for payment under subsection (b).

(2) CONTRACTING AUTHORITY.—The Secretary may enter into one or more contracts with entities for the purpose of implementation of this section.

(3) LIMITATION.—The Secretary may not spend more than 0.75 percent of the amount made available under subsection (a) in any year on the costs of administering the program of payments under this section for the year.

(4) IMPLEMENTATION.—Notwithstanding any other provision of law, the Secretary may implement, by program instruction or otherwise, the provisions of this section.

(5) LIMITATIONS ON REVIEW.—There shall be no administrative or judicial review of—

(A) the determination of the eligibility of a facility for payments under subsection (b); or

(B) the determination of the amount of any payment made to a facility under such subsection.

(d) ANNUAL REPORTS.—The Secretary shall submit an annual report to the committees with jurisdiction in the Congress on payments made under subsection (b). Each such report shall include information on—

(1) the facilities receiving such payments;

(2) the amount of such payments to such facilities; and

(3) the basis for selecting such facilities and the amount of such payments.

(e) REFERENCE TO REPORT.—For report by the Medicaid and CHIP Payment and Access Commission on the adequacy of payments to nursing facilities under the Medicaid program, see section 1900(b)(2)(B) of the Social Security Act, as amended by section 1784.

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

(1) DUALLY-CERTIFIED FACILITY.—The term ''dually-certified facility'' means a facility that is participating as a nursing facility under title XIX of the Social Security Act and as a skilled nursing facility under title XVIII of such Act.

(2) MEDICAID ELIGIBLE INDIVIDUAL.—The term ''Medicaid eligible individual'' means an individual who is eligible for medical assistance, with respect to nursing facility services (as defined in section 1905(f) of the Social Security Act), under title XIX of the such Act.

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

SEC. 1746. REPORT ON MEDICAID PAYMENTS.

Section 1902 of the Social Security Act (42 U.S.C. 1396), as amended by sections 1703(a), 1714(a), and 1731(a), is amended by adding at the end the following new subsection:

''(jj) REPORT ON MEDICAID PAYMENTS.—Each year, on or before a date determined by the Secretary, a State participating in the Medicaid program under this title shall submit to the Administrator of the Centers for Medicare & Medicaid Services—

''(1) information on the determination of rates of payment to providers for covered services under the State plan, including—

''(A) the final rates;

''(B) the methodologies used to determine such rates; and

''(C) justifications for the rates; and

''(2) an explanation of the process used by the State to allow providers, beneficiaries and their representatives, and other concerned State residents a reasonable opportunity to review and comment on such rates, methodologies, and justifications before the State made such rates final.''.

SEC. 1747. REVIEWS OF MEDICAID.

(a) GAO STUDY ON FMAP.—.

(1) STUDY.—The Comptroller General of the United States shall conduct a study regarding federal payments made to the State Medicaid programs under title XIX of the Social Security Act for the purposes of making recommendations to Congress.

(2) REPORT.—Not later than February 15, 2011, the Comptroller General shall submit to the appropriate committees of Congress a report on the study conducted under paragraph (1) and the effect

on the federal government, States, providers, and beneficiaries of—

(A) removing the 50 percent floor, or 83 percent ceiling, or both, in the Federal medical assistance percentage under section 1905(b)(1) of the Social Security Act; and

(B) revising the current formula for such Federal medical assistance percentage to better reflect State fiscal capacity and State effort to pay for health and long-term care services and to better adjust for national or regional economic downturns.

(b) GAO STUDY ON MEDICAID ADMINISTRATIVE COSTS..—

(1) STUDY.—The Comptroller General of the United States shall conduct a study of the administration of the Medicaid program by the Department of Health and Human Services, State Medicaid agencies, and local government agencies. The report shall address the following issues:

(A) The extent to which federal funds for each administrative function, such as survey and certification and claims processing, are being used effectively and efficiently.

(B) The administrative functions on which federal Medicaid funds are expended and the amounts of such expenditures (whether spent directly or by contract).

(2) REPORT.—Not later than February 15, 2011, the Comptroller General shall submit to the appropriate committees of Congress a report on the study conducted under paragraph (1).

SEC. 1748. EXTENSION OF DELAY IN MANAGED CARE ORGANIZATION PROVIDER TAX ELIMINATION.

Effective as if included in the enactment of section 6051 of the Deficit Reduction Act of 2005 (Public Law 109–171), subsection (b)(2)(A) of such section is amended by striking ''October 1, 2009'' and inserting ''October 1, 2010''.

SEC. 1749. EXTENSION OF ARRA INCREASE IN FMAP.

Section 5001 of the American Recovery and Reinvestment Act of 2009 (Public Law 111–5) is amended—

(1) in subsection (a)(3), by striking ''first calendar quarter'' and inserting ''first 3 calendar quarters'';

(2) in subsection (b)(2), by inserting before the period at the end the following: ''and such paragraph shall not apply to calendar quarters beginning on or after October 1, 2010'';

(3) in subsection (c)(4)(C)(ii), by striking ''December 2009'' and ''January 2010'' and inserting ''June 2010'' and ''July 2010'', respectively;

(4) in subsection (d), by inserting ''ending before October 1, 2010'' after ''entire fiscal years'' and after ''with respect to fiscal years'';

(5) in subsection (g)(1), by striking ''September 30, 2011'' and inserting ''December 31, 2011''; and

(6) in subsection (h)(3), by striking ''December 31, 2010'' and inserting ''June 30, 2011''.

Subtitle F—Waste, Fraud, and Abuse

SEC. 1751. HEALTH CARE ACQUIRED CONDITIONS.

(a) MEDICAID NON-PAYMENT FOR CERTAIN HEALTH CARE-ACQUIRED CONDITIONS.—Section 1903(i) of the Social Security Act (42 U.S.C. 1396b(i)) is amended—

(1) by striking ''or'' at the end of paragraph (23);

(2) by striking the period at the end of paragraph (24) and inserting ''; or''; and

(3) by inserting after paragraph (24) the following new paragraph:

''(25) with respect to amounts expended for services related to the presence of a condition that could be identified by a secondary diagnostic code

described in section 1886(d)(4)(D)(iv) and for any health care acquired condition determined as a non-covered service under title XVIII.''.

(b) APPLICATION TO CHIP.—Section 2107(e)(1)(G) of such Act (42 U.S.C. 1397gg(e)(1)(G)) is amended by striking ''and (17)'' and inserting ''(17), and (25)''.

(c) PERMISSION TO INCLUDE ADDITIONAL HEALTH CARE-ACQUIRED CONDITIONS.—Nothing in this section shall prevent a State from including additional health care-acquired conditions for non-payment in its Medicaid program under title XIX of the Social Security Act.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to discharges occurring on or after January 1, 2010.

SEC. 1752. EVALUATIONS AND REPORTS REQUIRED UNDER MEDICAID INTEGRITY PROGRAM.

Section 1936(c)(2)) of the Social Security Act (42 U.S.C. 1396u–7(c)(2)) is amended—

(1) by redesignating subparagraph (D) as subparagraph (E); and

(2) by inserting after subparagraph (C) the following new subparagraph:

''(D) For the contract year beginning in 2011 and each subsequent contract year, the entity provides assurances to the satisfaction of

the Secretary that the entity will conduct periodic evaluations of the effectiveness of the activities carried out by such entity under the Program and will submit to the Secretary an annual report on such activities.''.

SEC. 1753. REQUIRE PROVIDERS AND SUPPLIERS TO ADOPT PROGRAMS TO REDUCE WASTE, FRAUD, AND ABUSE.

Section 1902(a) of such Act (42 U.S.C. 42 U.S.C. 1396a(a)), as amended by sections 1631(b)(1), 1703, and 1729, is further amended—

(1) in paragraph (75), by striking at the end ''and'';

(2) in paragraph (76), by striking at the end the period and inserting ''; and''; and

(3) by inserting after paragraph (76) the following new paragraph:

''(77) provide that any provider or supplier (other than a physician or nursing facility) providing services under such plan shall, subject to paragraph (5) of section 1874(d), establish a compliance program described in paragraph (1) of such section in accordance with such section.''.

SEC. 1754. OVERPAYMENTS.

(a) IN GENERAL.—Section 1903(d)(2)(C) of the Social Security Act (42 U.S.C. 1396b(d)(2)(C)) is amended—

(1) in the first sentence, by inserting ''(or of 1 year in the case of overpayments due to fraud)'' after ''60 days''; and

(2) in the second sentence, by striking ''the 60 days'' and inserting ''such period''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply in the case of overpayments discovered on or after the date of the enactment of this Act.

SEC. 1755. MANAGED CARE ORGANIZATIONS.

(a) MINIMUM MEDICAL LOSS RATIO.—

(1) MEDICAID.—Section 1903(m)(2)(A) of the Social Security Act (42 U.S.C. 1396b(m)(2)(A)), as amended by section 1743(a)(3), is amended—

(A) by striking ''and'' at the end of clause (xii);

(B) by striking the period at the end of clause (xiii) and inserting ''; and''; and

(C) by adding at the end the following new clause:

''(xiv) such contract has a medical loss ratio, as determined in accordance with a methodology speci-

fied by the Secretary that is a percentage (not less than 85 percent) as specified by the Secretary.''.

(2) CHIP.—Section 2107(e)(1) of such Act (42 U.S.C. 1397gg(e)(1)) is amended—

(A) by redesignating subparagraphs (H) through (L) as subparagraphs (I) through (M); and

(B) by inserting after subparagraph (G) the following new subparagraph:

''(H) Section 1903(m)(2)(A)(xiv) (relating to application of minimum loss ratios), with respect to comparable contracts under this title.''.

(3) EFFECTIVE DATE.—The amendments made by this subsection shall apply to contracts entered into or renewed on or after July 1, 2010.

(b) PATIENT ENCOUNTER DATA.—

(1) IN GENERAL.—Section 1903(m)(2)(A)(xi) of the Social Security Act (42 U.S.C. 1396b(m)(2)(A)(xi)) is amended by inserting ''and for the provision of such data to the State at a frequency and level of detail to be specified by the Secretary'' after ''patients''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply with respect to contract years beginning on or after January 1, 2010.

SEC. 1756. TERMINATION OF PROVIDER PARTICIPATION UNDER MEDICAID AND CHIP IF TERMINATED UNDER MEDICARE OR OTHER STATE PLAN OR CHILD HEALTH PLAN.

(a) STATE PLAN REQUIREMENT.—Section 1902(a)(39) of the Social Security Act (42 U.S.C. 42 U.S.C. 1396a(a)) is amended by inserting after ''1128A,'' the following: ''terminate the participation of any individual or entity in such program if (subject to such exceptions are permitted with respect to exclusion under sections 1128(b)(3)(C) and 1128(d)(3)(B)) participation of such individual or entity is terminated under title XVIII, any other State plan under this title, or any child health plan under title XXI,''.

(b) APPLICATION TO CHIP.—Section 2107(e)(1)(A) of such Act (42 U.S.C. 1397gg(e)(1)(A)) is amended by inserting before the period at the end the following: ''and section 1902(a)(39) (relating to exclusion and termination of participation)''.

(c) EFFECTIVE DATE.—Except as provided in section 1790, the amendments made by this section shall apply to services furnished on or after January 1, 2011, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.

SEC. 1757. MEDICAID AND CHIP EXCLUSION FROM PARTICIPATION RELATING TO CERTAIN OWNERSHIP, CONTROL, AND MANAGEMENT AFFILIATIONS.

(a) STATE PLAN REQUIREMENT.—Section 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)), as amended by sections 1631(b)(1), 1703(a), 1729, and 1753, is further amended—

(1) in paragraph (76), by striking at the end ''and'';

(2) in paragraph (77), by striking at the end the period and inserting ''; and''; and

(3) by inserting after paragraph (77) the following new paragraph:

''(78) provide that the State agency described in paragraph (9) exclude, with respect to a period, any individual or entity from participation in the program under the State plan if such individual or entity owns, controls, or manages an entity that (or if such entity is owned, controlled, or managed by an individual or entity that)—

''(A) has unpaid overpayments under this title during such period determined by the Secretary or the State agency to be delinquent;

''(B) is suspended or excluded from participation under or whose participation is terminated under this title during such period; or

''(C) is affiliated with an individual or entity that has been suspended or excluded from participation under this title or whose participation is terminated under this title during such period.''.

(b) CHILD HEALTH PLAN REQUIREMENT.—Section 2107(e)(1)(A) of such Act (42 U.S.C. 1397gg(e)(1)(A)), as amended by section 1756(b), is amended by striking ''section 1902(a)(39)'' and inserting ''sections 1902(a)(39) and 1902(a)(78)''.

(c) EFFECTIVE DATE.—Except as provided in section 1790, the amendments made by this section shall apply to services furnished on or after January 1, 2011, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.

SEC. 1758. REQUIREMENT TO REPORT EXPANDED SET OF DATA ELEMENTS UNDER MMIS TO DETECT FRAUD AND ABUSE.

Section 1903(r)(1)(F) of the Social Security Act (42 U.S.C. 1396b(r)(1)(F)) is amended by inserting after ''necessary'' the following: ''and including, for data submitted to the Secretary on or after July 1, 2010, data elements from the automated data system that the Secretary determines to be necessary for detection of waste, fraud, and abuse''.

SEC. 1759. BILLING AGENTS, CLEARINGHOUSES, OR OTHER ALTERNATE PAYEES REQUIRED TO REGISTER UNDER MEDICAID.

(a) IN GENERAL.—Section 1902(a) of the Social Security Act (42 U.S.C. 42 U.S.C. 1396a(a)), as amended by sections 1631(b), 1703(a), 1729, 1753, and 1757(a), is further amended—

(1) in paragraph (77); by striking at the end ''and'';

(2) in paragraph (78), by striking the period at the end and inserting ''and''; and

(3) by inserting after paragraph (78) the following new paragraph:

''(79) provide that any agent, clearinghouse, or other alternate payee that submits claims on behalf of a health care provider must register with the State and the Secretary in a form and manner specified by the Secretary under section 1866(j)(1)(D).''.

(b) DENIAL OF PAYMENT.—Section 1903(i) of such Act (42 U.S.C. 1396b(i)), as amended by section 1751, is amended—

(1) by striking ''or'' at the end of paragraph (24);

(2) by striking the period at the end of paragraph (25) and inserting ''; or''; and

(3) by inserting after paragraph (25) the following new paragraph:

''(26) with respect to any amount paid to a billing agent, clearinghouse, or other alternate payee that is not registered with the State and the Secretary as required under section 1902(a)(79).''.

(c) EFFECTIVE DATE.—Except as provided in section 1790, the amendments made by this section shall apply to claims submitted on or after January 1, 2012, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.

SEC. 1760. DENIAL OF PAYMENTS FOR LITIGATION-RELATED MISCONDUCT.

(a) IN GENERAL.—Section 1903(i) of the Social Security Act (42 U.S.C. 1396b(i)), as amended by sections 1751(a) and 1759(b), is amended—

(1) by striking ''or'' at the end of paragraph (25);

(2) by striking the period at the end of paragraph (26) and inserting ''; or''; and

(3) by inserting after paragraph (26) the following new paragraph:

''(27) with respect to any amount expended—

''(A) on litigation in which a court imposes sanctions on the State, its employees, or its counsel for litigation-related misconduct; or

''(B) to reimburse (or otherwise compensate) a managed care entity for payment of legal expenses associated with any action in which a court imposes sanctions on the managed care entity for litigation-related misconduct.''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to amounts expended on or after January 1, 2010.

SEC. 1761. MANDATORY STATE USE OF NATIONAL CORRECT CODING INITIATIVE.

Section 1903(r) of the Social Security Act (42 U.S.C. 1396b(r)) is amended—

(1) in paragraph (1)(B)—

(A) in clause (ii), by striking ''and'' at the end;

(B) in clause (iii), by adding ''and'' at the end; and

(C) by adding at the end the following new clause:

''(iv) effective for claims filed on or after October 1, 2010, incorporate compat-

ible methodologies of the National Correct Coding Initiative administered by the Secretary (or any successor initiative to promote correct coding and to control improper coding leading to inappropriate payment) and such other methodologies of that Initiative (or such other national correct coding methodologies) as the Secretary identifies in accordance with paragraph (4);''; and

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

''(4) Not later than September 1, 2010, the Secretary shall do the following:

''(A) Identify those methodologies of the National Correct Coding Initiative administered by the Secretary (or any successor initiative to promote correct coding and to control improper coding leading to inappropriate payment) which are compatible to claims filed under this title.

''(B) Identify those methodologies of such Initiative (or such other national correct coding methodologies) that should be incorporated into claims filed under this title with respect to items or services for which States provide medical assistance under

this title and no national correct coding methodologies have been established under such Initiative with respect to title XVIII.

''(C) Notify States of—

''(i) the methodologies identified under subparagraphs (A) and (B) (and of any other national correct coding methodologies identified under subparagraph (B)); and

''(ii) how States are to incorporate such methodologies into claims filed under this title.

''(D) Submit a report to Congress that includes the notice to States under subparagraph (C) and an analysis supporting the identification of the methodologies made under subparagraphs (A) and (B).''.

Subtitle G—Payments to the Territories

SEC. 1771. PAYMENT TO TERRITORIES.

(a) INCREASE IN CAP.—Section 1108 of the Social Security Act (42 U.S.C. 1308) is amended—

(1) in subsection (f), by striking ''subsection (g)'' and inserting ''subsections (g) and (h)'';

(2) in subsection (g)(1), by striking ''With respect to'' and inserting ''Subject to subsection (h), with respect to''; and

(3) by adding at the end the following new subsection:

''(h) ADDITIONAL INCREASE FOR FISCAL YEARS 2011 THROUGH 2019.—Subject to section 347(b)(1) of the Affordable Health Care for America Act, with respect to fiscal years 2011 through 2019, the amounts otherwise determined under subsections (f) and (g) for Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands and American Samoa shall be increased by the following amounts:

''(1) For Puerto Rico, for fiscal year 2011, $727,600,000; for fiscal year 2012, $775,000,000; for fiscal year 2013, $850,000,000; for fiscal year 2014, $925,000,000; for fiscal year 2015, $1,000,000,000; for fiscal year 2016, $1,075,000,000; for fiscal year 2017, $1,150,000,000; for fiscal year 2018, $1,225,000,000; and for fiscal year 2019, $1,396,400,000.

''(2) For the Virgin Islands, for fiscal year 2011, $34,000,000; for fiscal year 2012, $37,000,000; for fiscal year 2013, $40,000,000; for fiscal year 2014, $43,000,000; for fiscal year 2015, $46,000,000; for fiscal year 2016, $49,000,000; for

fiscal year 2017, $52,000,000; for fiscal year 2018, $55,000,000; and for fiscal year 2019, $58,000,000.

''(3) For Guam, for fiscal year 2011, $34,000,000; for fiscal year 2012, $37,000,000; for fiscal year 2013, $40,000,000; for fiscal year 2014, $43,000,000; for fiscal year 2015, $46,000,000; for fiscal year 2016, $49,000,000; for fiscal year 2017, $52,000,000; for fiscal year 2018, $55,000,000; and for fiscal year 2019, $58,000,000.

''(4) For the Northern Mariana Islands, for fiscal year 2011, $13,500,000; fiscal year 2012, $14,500,000; for fiscal year 2013, $15,500,000; for fiscal year 2014, $16,500,000; for fiscal year 2015, $17,500,000; for fiscal year 2016, $18,500,000; for fiscal year 2017, $19,500,000; for fiscal year 2018, $21,000,000; and for fiscal year 2019, $22,000,000.

''(5) For American Samoa, fiscal year 2011, $22,000,000; fiscal year 2012, $23,687,500; for fiscal year 2013, $24,687,500; for fiscal year 2014, $25,687,500; for fiscal year 2015, $26,687,500; for fiscal year 2016, $27,687,500; for fiscal year 2017, $28,687,500; for fiscal year 2018, $29,687,500; and for fiscal year 2019, $30,687,500.''.

(b) REPORT ON ACHIEVING MEDICAID PARITY PAYMENTS BEGINNING WITH FISCAL YEAR 2020.—

(1) IN GENERAL.—Not later than October 1, 2013, the Secretary of Health and Human Services shall submit to Congress a report that details a plan for the transition of each territory to full parity in Medicaid with the 50 States and the District of Columbia in fiscal year 2020 by modifying their existing Medicaid programs and outlining actions the Secretary and the governments of each territory must take by fiscal year 2020 to ensure parity in financing. Such report shall include what the Federal medical assistance percentages would be for each territory if the formula applicable to the 50 States were applied. Such report shall also include any recommendations that the Secretary may have as to whether the mandatory ceiling amounts for each territory provided for in section 1108 of the Social Security Act (42 U.S.C. 1308) should be increased any time before fiscal year 2020 due to any factors that the Secretary deems relevant.

(2) PER CAPITA DATA.—As part of such report the Secretary shall include information about per capita income data that could be used to calculate Federal medical assistance percentages under section 1905(b) of the Social Security Act, under section 1108(a)(8)(B) of such Act, for each territory on how

such data differ from the per capita income data used to promulgate Federal medical assistance percentages for the 50 States. The report under this subsection shall include recommendations on how the Federal medical assistance percentages can be calculated for the territories beginning in fiscal year 2020 to ensure parity with the 50 States.

(3) SUBSEQUENT REPORTS.—The Secretary shall submit subsequent reports to Congress in 2015, 2017, and 2019 detailing the progress that the Secretary and the governments of each territory have made in fulfilling the actions outlined in the plan submitted under paragraph (1).

(c) APPLICATION OF FMAP FOR ADDITIONAL FUNDS.—Section 1905(b) of such Act (42 U.S.C. 1396d(b)) is amended by adding at the end the following sentence: ''Notwithstanding the first sentence of this subsection and any other provision of law, for fiscal years 2011 through 2019, the Federal medical assistance percentage for Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa shall be the highest Federal medical assistance percentage applicable to any of the 50 States or the District of Columbia for the fiscal year involved, taking into account the application of subsections (a) and (b)(1) of section 5001 of di-

vision B of the American Recovery and Reinvestment Act of 2009 (Public Law 111–5) to such States and the District for calendar quarters during such fiscal years for which such subsections apply.''.

(d) WAIVERS.—

(1) IN GENERAL.—Section 1902(j) of the Social Security Act (42 U.S.C. 1396a(j)) is amended—

(A) by striking ''American Samoa and the Northern Mariana Islands'' and inserting ''Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa''; and

(B) by striking ''American Samoa or the Northern Mariana Islands'' and inserting ''Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, or American Samoa''.

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall apply beginning with fiscal year 2011.

(e) TECHNICAL ASSISTANCE.—The Secretary shall provide nonmonetary technical assistance to the governments of Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa in upgrading their existing computer systems in order to antici-

pate meeting reporting requirements necessary to implement the plan contained in the report under subsection (b)(1).

Subtitle H—Miscellaneous

SEC. 1781. TECHNICAL CORRECTIONS.

(a) TECHNICAL CORRECTION TO SECTION 1144 OF THE SOCIAL SECURITY ACT.—The first sentence of section 1144(c)(3) of the Social Security Act (42 U.S.C. 1320b—14(c)(3)) is amended—

(1) by striking ''transmittal''; and

(2) by inserting before the period the following: ''as specified in section 1935(a)(4)''.

(b) CLARIFYING AMENDMENT TO SECTION 1935 OF THE SOCIAL SECURITY ACT.—Section 1935(a)(4) of the Social Security Act (42 U.S.C. 1396u—5(a)(4)), as amended by section 113(b) of Public Law 110–275, is amended—

(1) by striking the second sentence;

(2) by redesignating the first sentence as a subparagraph (A) with appropriate indentation and with the following heading: ''IN GENERAL.—'';

(3) by adding at the end the following subparagraphs:

''(B) FURNISHING MEDICAL ASSISTANCE WITH REASONABLE PROMPTNESS.—For the

purpose of a State's obligation under section 1902(a)(8) to furnish medical assistance with reasonable promptness, the date of the electronic transmission of low-income subsidy program data, as described in section 1144(c), from the Commissioner of Social Security to the State Medicaid Agency, shall constitute the date of filing of such application for benefits under the Medicare Savings Program.

''(C) DETERMINING AVAILABILITY OF MEDICAL ASSISTANCE.—For the purpose of determining when medical assistance will be made available, the State shall consider the date of the individual's application for the low income subsidy program to constitute the date of filing for benefits under the Medicare Savings Program.''.

(c) EFFECTIVE DATE RELATING TO MEDICAID AGENCY CONSIDERATION OF LOW-INCOME SUBSIDY APPLICATION AND DATA TRANSMITTAL.—The amendments made by subsections (a) and (b) shall be effective as if included in the enactment of section 113(b) of Public Law 110–275.

(d) TECHNICAL CORRECTION TO SECTION 605 OF CHIPRA.—Section 605 of the Children's Health Insur-

ance Program Reauthorization Act of 2009 (Public Law 111–3) is amended by striking ''legal residents'' and inserting ''lawfully residing in the United States''.

(e) TECHNICAL CORRECTION TO SECTION 1905 OF THE SOCIAL SECURITY ACT.—Section 1905(a) of the Social Security Act (42 U.S.C. 1396d(a)) is amended by inserting ''or the care and services themselves, or both'' before ''(if provided in or after''.

(f) CLARIFYING AMENDMENT TO SECTION 1115 OF THE SOCIAL SECURITY ACT.—Section 1115(a) of the Social Security Act (42 U.S.C. 1315(a)) is amended by adding at the end the following: ''If an experimental, pilot, or demonstration project that relates to title XIX is approved pursuant to any part of this subsection, such project shall be treated as part of the State plan, all medical assistance provided on behalf of any individuals affected by such project shall be medical assistance provided under the State plan, and all provisions of this Act not explicitly waived in approving such project shall remain fully applicable to all individuals receiving benefits under the State plan.''.

SEC. 1782. EXTENSION OF QI PROGRAM.

(a) IN GENERAL.—Section 1902(a)(10)(E)(iv) of the Social Security Act (42 U.S.C. 1396b(a)(10)(E)(iv)) is amended—

(1) by striking ''sections 1933 and'' and by inserting ''section''; and

(2) by striking ''December 2010'' and inserting ''December 2012''.

(b) ELIMINATION OF FUNDING LIMITATION.—

(1) IN GENERAL.—Section 1933 of such Act (42 U.S.C. 1396u–3) is amended—

(A) in subsection (a), by striking ''who are selected to receive such assistance under subsection (b)'';

(B) by striking subsections (b), (c), (e), and (g);

(C) in subsection (d), by striking ''furnished in a State'' and all that follows and inserting ''the Federal medical assistance percentage shall be equal to 100 percent.''; and

(D) by redesignating subsections (d) and (f) as subsections (b) and (c), respectively.

(2) CONFORMING AMENDMENT.—Section 1905(b) of such Act (42 U.S.C. 1396d(b)) is amended by striking ''1933(d)'' and inserting ''1933(b)''.

(3) EFFECTIVE DATE.—The amendments made by paragraph (1) shall take effect on January 1, 2011.

SEC. 1783. ASSURING TRANSPARENCY OF INFORMATION.

(a) IN GENERAL.—Section 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)), as amended by sections 1631(b), 1703(a), 1729, 1753, 1757(a), 1759(a), and 1907(b), is amended—

(1) by striking ''and'' at the end of paragraph (79);

(2) by striking the period at the end of paragraph (80) and inserting ''; and''; and

(3) by inserting after paragraph (80) the following new paragraph:

''(81) provide that the State will establish and maintain laws, in accordance with the requirements of section 1921A, to require disclosure of information on hospital charges and quality and to make such information available to the public and the Secretary.''; and

(4) by inserting after section 1921 the following new section:

''HOSPITAL PRICE TRANSPARENCY

''SEC. 1921A. (a) IN GENERAL.—The requirements referred to in section 1902(a)(81) are that the laws of a State must—

''(1) require reporting to the State (or its agent) by each hospital located therein, of information on,—

''(A) the charges for the most common inpatient and outpatient hospital services;

''(B) the Medicare and Medicaid reimbursement amount for such services; and

''(C) if the hospitals allows for or provides reduced charges for individuals based on financial need, the factors considered in making determinations for reductions in charges, including any formula for such determination and the contact information for the specific department of a hospital that responds to such inquiries;

''(2) provide for notice to individuals seeking or requiring such services of the availability of information on charges described in paragraph (1);

''(3) provide for timely access to such information, including at least through an Internet website, by individuals seeking or requiring such services; and

''(4) provide for timely access to information regarding the quality of care at each hospital made publicly available in accordance with section 501 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173), section 1139A, or section 1139B.

The Secretary shall consult with stakeholders (including those entities in section 1808(d)(6) and the National Governors Association) through a formal process to obtain guidance prior to issuing implementing policies under this section.

''(b) HOSPITAL DEFINED.—For purposes of this section, the term 'hospital' means an institution that meets the requirements of paragraphs (1) and (7) of section 1861(e) and includes those to which section 1820(c) applies.''.

(b) EFFECTIVE DATE; ADMINISTRATION.—

(1) IN GENERAL.—Except as provided in paragraphs (2)(B) and section 1790, the amendments made by subsection (a) shall take effect on October 1, 2010.

(2) EXISTING PROGRAMS.—

(A) IN GENERAL.—The Secretary of Health and Human Services shall establish a process by which a State with an existing program may certify to the Secretary that its program satisfies the requirements of section 1921A of the Social Security Act, as inserted by subsection (a).

(B) 2-YEAR PERIOD TO BECOME IN COMPLIANCE.—States that, as of the date of the en-

actment of this Act, administer hospital price transparency policies that do not meet such requirements shall have 2 years from such date to make necessary modifications to come into compliance and shall not be regarded as failing to comply with such requirements during such 2-year period.

SEC. 1784. MEDICAID AND CHIP PAYMENT AND ACCESS COMMISSION.

(a) REPORT ON NURSING FACILITY PAYMENT POLICIES.—Section 1900(b) of the Social Security Act (42 U.S.C. 1396(b)) is amended by adding at the end the following new paragraph:

"(10) REPORTS ON SPECIAL TOPICS ON PAYMENT POLICIES.—

"(A) NURSING FACILITY PAYMENT POLICIES.—Not later than January 1, 2012, the Commission shall submit to Congress a report on nursing facility payment policies under Medicaid that includes—

"(i) information on the difference between the amount paid by each State to nursing facilities in such State under the Medicaid program under this title and the cost to such facilities of providing efficient

quality care to Medicaid eligible individuals;

''(ii) an evaluation of patient outcomes and quality as a result of the supplemental payments under section 1745(b) of the Affordable Health Care for America Act; and

''(iii) whether adjustments should be made under the Medicaid program to the rates that States pay skilled nursing facilities to ensure that such rates are sufficient to provide efficient quality care to Medicaid eligible individuals.''.

(b) PEDIATRIC SUBSPECIALIST PAYMENT POLICIES.—Section 1900(b)(10) of the Social Security Act, as added by subsection (a) is amended by adding at the end the following new subparagraph:

''(B) PEDIATRIC SUBSPECIALIST PAYMENT POLICIES.—Not later than January 1, 2011, the Commission shall submit to Congress a report on payment policies for pediatric subspecialist services under Medicaid that includes—

''(i) a comprehensive review of each State's Medicaid payment rates for inpa-

tient and outpatient pediatric speciality services;

''(ii) a comparison, on a State-by-State basis, of the rates under clause (i) to Medicare payments for similar services;

''(iii) information on any limitations in patient access to pediatric speciality care, such as delays in receiving care or wait times for receiving care;

''(iv) an analysis of the extent to which low Medicaid payment rates in any State contributes to limits in access to pediatric subspecialty services in such State; and

''(v) recommendations to ameliorate any problems found with such payment rates or with access to such services.''.

(c) ADDITIONAL AMENDMENTS.—

(1) COMMISSION STATUS.—Section 1900(a) of the Social Security Act is amended by inserting ''as an agency of Congress'' after ''established''.

(2) EXPANSION OF SCOPE.—Section 1900(b)(1)(A) of the Social Security Act is amended by striking ''children's access'' and inserting ''access

by low-income children and other eligible individuals''.

(3) CHANGE IN REPORT DEADLINES.—Subparagraphs (C) and (D) of section 1900(b)(1) of such Act are amended by striking ''2010'' and inserting ''2011'' each place it appears.

(4) REPORT IN HEALTH REFORM.—Section 1900(b)(2) of such Act is amended—

(A) in subparagraph (A)(i), by striking ''skilled'';

(B) by striking subparagraph (B);

(C) by redesignating subparagraph (C) as subparagraph (B); and

(D) by adding at the end the following new subparagraph:

''(C) IMPLEMENTATION OF HEALTH REFORM.—The implementation of the provisions of the Affordable Health Care for America Act that relate to Medicaid or CHIP by the Secretary, the Health Choices Commissioner, and the States, including the effect of such implementation on the access to needed health care items and services by low-income individuals and families.''.

(5) CLARIFICATION OF MEMBERSHIP.—Section 1900(c)(2)(B) of such Act is amended by striking ''consumers'' and inserting ''individuals''.

(6) AUTHORIZATION OF APPROPRIATIONS.—

(A) CURRENT AUTHORIZATION.—Section 1900(f)(2) of such Act is amended—

(i) in the heading, by inserting ''OF APPROPRIATIONS PRIOR TO 2010'' after ''AUTHORIZATION''; and

(ii) by striking ''There are'' and inserting ''Prior to January 1, 2010, there are''

(B) FUTURE AUTHORIZATION.—Section 1900(f) of such Act is further amended by adding at the end the following new paragraph: after the period the following:

''(3) AUTHORIZATION OF APPROPRIATIONS FOR 2010.—Beginning on January 1, 2010, there is authorized to be appropriated $11,800,000 to carry out the provisions of this section. Such funds shall remain available until expended.''.

SEC. 1785. OUTREACH AND ENROLLMENT OF MEDICAID AND CHIP ELIGIBLE INDIVIDUALS.

(a) IN GENERAL.—Not later than 12 months after date of enactment of this Act, the Secretary of Health and

Human Services shall issue guidance regarding standards and best practices for conducting outreach to inform eligible individuals about healthcare coverage under Medicaid under title XIX of the Social Security Act or for child health assistance under CHIP under title XXI of such Act, providing assistance to such individuals for enrollment in applicable programs, and establishing methods or procedures for eliminating application and enrollment barriers. Such guidance shall include provisions to ensure that outreach, enrollment assistance, and administrative simplification efforts are targeted specifically to vulnerable populations such as children, unaccompanied homeless youth, victims of abuse or trauma, individuals with mental health or substance related disorders, and individuals with HIV/AIDS. Guidance issued pursuant to this section relating to methods to increase outreach and enrollment provided for under titles XIX and XXI of the Social Security Act shall specifically target such vulnerable and underserved populations and shall include, but not be limited to, guidance on outstationing of eligibility workers, express lane eligibility, residence requirements, documentation of income and assets, presumptive eligibility, continuous eligibility, and automatic renewal.

(b) IMPLEMENTATION.—In implementing the requirements under subsection (a), the Secretary may use

such authorities as are available under law and may work with such entities as the Secretary deems appropriate to facilitate effective implementation of such programs. Not later than 2 years after the enactment of this Act and annually thereafter, the Secretary shall review and report to Congress on progress in implementing targeted outreach, application and enrollment assistance, and administrative simplification methods for such vulnerable and underserved populations as are specified in subsection (a).

SEC. 1786. PROHIBITIONS ON FEDERAL MEDICAID AND CHIP PAYMENT FOR UNDOCUMENTED ALIENS.

Nothing in this title shall change current prohibitions against Federal Medicaid and CHIP payments under titles XIX and XXI of the Social Security Act on behalf of individuals who are not lawfully present in the United States.

SEC. 1787. DEMONSTRATION PROJECT FOR STABILIZATION OF EMERGENCY MEDICAL CONDITIONS BY INSTITUTIONS FOR MENTAL DISEASES.

(a) AUTHORITY TO CONDUCT DEMONSTRATION PROJECT.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall establish a demonstration project under which an eligible State (as described in subsection (c)) shall provide reimbursement under the State Medicaid plan under title XIX of

the Social Security Act to an institution for mental diseases that is subject to the requirements of section 1867 of the Social Security Act (42 U.S.C. 1395dd) for the provision of medical assistance available under such plan to an individual who—

(1) has attained age 21, but has not attained age 65;

(2) is eligible for medical assistance under such plan; and

(3) requires such medical assistance to stabilize an emergency medical condition.

(b) IN-STAY REVIEW.—The Secretary shall establish a mechanism for in-stay review to determine whether or not the patient has been stabilized (as defined in subsection (h)(5)). This mechanism shall commence before the third day of the inpatient stay. States participating in the demonstration project may manage the provision of these benefits under the project through utilization review, authorization, or management practices, or the application of medical necessity and appropriateness criteria applicable to behavioral health.

(c) ELIGIBLE STATE DEFINED.—

(1) APPLICATION.—Upon approval of an application submitted by a State described in paragraph (2), the State shall be an eligible State for purposes

of conducting a demonstration project under this section.

(2) STATE DESCRIBED.—States shall be selected by the Secretary in a manner so as to provide geographic diversity on the basis of the application to conduct a demonstration project under this section submitted by such States.

(d) LENGTH OF DEMONSTRATION PROJECT.—The demonstration project established under this section shall be conducted for a period of 3 consecutive years.

(e) LIMITATIONS ON FEDERAL FUNDING.—

(1) APPROPRIATION.—

(A) IN GENERAL.—Out of any funds in the Treasury not otherwise appropriated, there is appropriated to carry out this section, $75,000,000 for fiscal year 2010.

(B) BUDGET AUTHORITY.—Subparagraph (A) constitutes budget authority in advance of appropriations Act and represents the obligation of the Federal Government to provide for the payment of the amounts appropriated under that subparagraph.

(2) 3-YEAR AVAILABILITY.—Funds appropriated under paragraph (1) shall remain available for obligation through December 31, 2012.

(3) LIMITATION ON PAYMENTS.—In no case may—

(A) the aggregate amount of payments made by the Secretary to eligible States under this section exceed $75,000,000; or

(B) payments be provided by the Secretary under this section after December 31, 2012.

(4) FUNDS ALLOCATED TO STATES.—The Secretary shall allocate funds to eligible States based on their applications and the availability of funds.

(5) PAYMENTS TO STATES.—The Secretary shall pay to each eligible State, from its allocation under paragraph (4), an amount each quarter equal to the Federal medical assistance percentage of expenditures in the quarter for medical assistance described in subsection (a).

(f) REPORTS.—

(1) ANNUAL PROGRESS REPORTS.—The Secretary shall submit annual reports to Congress on the progress of the demonstration project conducted under this section.

(2) FINAL REPORT AND RECOMMENDATION.—An evaluation shall be conducted of the demonstration project's impact on the functioning of the health and mental health service system and on individuals

enrolled in the Medicaid program. This evaluation shall include collection of baseline data for one-year prior to the initiation of the demonstration project as well as collection of data from matched comparison states not participating in the demonstration. The evaluation measures shall include the following:

(A) A determination, by State, as to whether the demonstration project resulted in increased access to inpatient mental health services under the Medicaid program and whether average length of stays were longer (or shorter) for individuals admitted under the demonstration project compared with individuals otherwise admitted in comparison sites.

(B) An analysis, by State, regarding whether the demonstration project produced a significant reduction in emergency room visits for individuals eligible for assistance under the Medicaid program or in the duration of emergency room lengths of stay.

(C) An assessment of discharge planning by participating hospitals that ensures access to further (non-emergency) inpatient or residential care as well as continuity of care for those discharged to outpatient care.

(D) An assessment of the impact of the demonstration project on the costs of the full range of mental health services (including inpatient, emergency and ambulatory care) under the plan as contrasted with the comparison areas.

(E) Data on the percentage of consumers with Medicaid coverage who are admitted to inpatient facilities as a result of the demonstration project as compared to those admitted to these same facilities through other means.

(F) A recommendation regarding whether the demonstration project should be continued after December 31, 2012, and expanded on a national basis.

(g) WAIVER AUTHORITY.—

(1) IN GENERAL.—The Secretary shall waive the limitation of subdivision (B) following paragraph (28) of section 1905(a) of the Social Security Act (42 U.S.C. 1396d(a)) (relating to limitations on payments for care or services for individuals under 65 years of age who are patients in an institution for mental diseases) for purposes of carrying out the demonstration project under this section.

(2) LIMITED OTHER WAIVER AUTHORITY.—The Secretary may waive other requirements of title XIX of the Social Security Act (including the requirements of sections 1902(a)(1) (relating to statewideness) and 1902(1)(10)(B) (relating to comparability)) only to extent necessary to carry out the demonstration project under this section.

(h) DEFINITIONS.—In this section:

(1) EMERGENCY MEDICAL CONDITION.—The term ''emergency medical condition'' means, with respect to an individual, an individual who expresses suicidal or homicidal thoughts or gestures, if determined dangerous to self or others.

(2) FEDERAL MEDICAL ASSISTANCE PERCENTAGE.—The term ''Federal medical assistance percentage'' has the meaning given that term with respect to a State under section 1905(b) of the Social Security Act (42 U.S.C. 1396d(b)).

(3) INSTITUTION FOR MENTAL DISEASES.—The term ''institution for mental diseases'' has the meaning given to that term in section 1905(i) of the Social Security Act (42 U.S.C. 1396d(i)).

(4) MEDICAL ASSISTANCE.—The term ''medical assistance'' has the meaning given to that term in

section 1905(a) of the Social Security Act (42 U.S.C. 1396d(a)).

(5) STABILIZED.—The term ''stabilized'' means, with respect to an individual, that the emergency medical condition no longer exists with respect to the individual and the individual is no longer dangerous to self or others.

(6) STATE.—The term ''State'' has the meaning given that term for purposes of title XIX of the Social Security Act (42 U.S.C. 1396 et seq.).

SEC. 1788. APPLICATION OF MEDICAID IMPROVEMENT FUND.

Section 1941(b)(1) of the Social Security Act (42 U.S.C. 1396w–1(b)(1)) is amended by striking ''from the Fund'' and all that follows and inserting ''from the Fund, only such amounts as may be appropriated or otherwise made available by law.''.

SEC. 1789. TREATMENT OF CERTAIN MEDICAID BROKERS.

Section 1903(b)(4) of the Social Security Act (42 U.S.C. 1396b(b)(4)) is amended—

(1) in the matter before subparagraph (A), by inserting after ''respect to the broker'' the following: ''(or, in the case of subparagraph (A) and subparagraph (B)(i), if the Inspector General of Department of Health and Human Services finds that the broker

has established and maintains procedures to ensure the independence of its enrollment activities from the interests of any managed care entity or provider)''; and

(2) in subparagraph (B)—

(A) by inserting ''(i)'' after ''either''; and

(B) by inserting ''(ii)'' after ''health care provider or''.

SEC. 1790. RULE FOR CHANGES REQUIRING STATE LEGISLATION.

In the case of a State plan for medical assistance under title XIX of the Social Security Act which the Secretary of Health and Human Services determines requires State legislation (other than legislation appropriating funds) in order for the plan to meet an additional requirement imposed by an amendment made by this title, the State plan shall not be regarded as failing to comply with the requirements of such title XIX solely on the basis of its failure to meet this additional requirement before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of

such session shall be deemed to be a separate regular session of the State legislature.

TITLE VIII—REVENUE-RELATED PROVISIONS

SEC. 1801. DISCLOSURES TO FACILITATE IDENTIFICATION OF INDIVIDUALS LIKELY TO BE INELIGIBLE FOR THE LOW-INCOME ASSISTANCE UNDER THE MEDICARE PRESCRIPTION DRUG PROGRAM TO ASSIST SOCIAL SECURITY ADMINISTRATION'S OUTREACH TO ELIGIBLE INDIVIDUALS.

(a) IN GENERAL.—Paragraph (19) of section 6103(l) of the Internal Revenue Code of 1986 is amended to read as follows:

''(19) DISCLOSURES TO FACILITATE IDENTIFICATION OF INDIVIDUALS LIKELY TO BE INELIGIBLE FOR LOW-INCOME SUBSIDIES UNDER MEDICARE PRESCRIPTION DRUG PROGRAM TO ASSIST SOCIAL SECURITY ADMINISTRATION'S OUTREACH TO ELIGIBLE INDIVIDUALS.—

''(A) IN GENERAL.—Upon written request from the Commissioner of Social Security, the following return information (including such information disclosed to the Social Security Administration under paragraph (1) or (5)) shall

be disclosed to officers and employees of the Social Security Administration, with respect to any taxpayer identified by the Commissioner of Social Security—

''(i) return information for the applicable year from returns with respect to wages (as defined in section 3121(a) or 3401(a)) and payments of retirement income (as described in paragraph (1) of this subsection),

''(ii) unearned income information and income information of the taxpayer from partnerships, trusts, estates, and subchapter S corporations for the applicable year,

''(iii) if the individual filed an income tax return for the applicable year, the filing status, number of dependents, income from farming, and income from self-employment, on such return,

''(iv) if the individual is a married individual filing a separate return for the applicable year, the social security number (if reasonably available) of the spouse on such return,

''(v) if the individual files a joint return for the applicable year, the social security number, unearned income information, and income information from partnerships, trusts, estates, and subchapter S corporations of the individual's spouse on such return, and

''(vi) such other return information relating to the individual (or the individual's spouse in the case of a joint return) as is prescribed by the Secretary by regulation as might indicate that the individual is likely to be ineligible for a low-income prescription drug subsidy under section 1860D–14 of the Social Security Act.

''(B) APPLICABLE YEAR.—For the purposes of this paragraph, the term 'applicable year' means the most recent taxable year for which information is available in the Internal Revenue Service's taxpayer information records.

''(C) RESTRICTION ON INDIVIDUALS FOR WHOM DISCLOSURE MAY BE REQUESTED.—The Commissioner of Social Security shall request information under this paragraph only with respect to—

''(i) individuals the Social Security Administration has identified, using all other reasonably available information, as likely to be eligible for a low-income prescription drug subsidy under section 1860D–14 of the Social Security Act and who have not applied for such subsidy, and

''(ii) any individual the Social Security Administration has identified as a spouse of an individual described in clause (i).

''(D) RESTRICTION ON USE OF DISCLOSED INFORMATION.—Return information disclosed under this paragraph may be used only by officers and employees of the Social Security Administration solely for purposes of identifying individuals likely to be ineligible for a low-income prescription drug subsidy under section 1860D–14 of the Social Security Act for use in outreach efforts under section 1144 of the Social Security Act.''.

(b) SAFEGUARDS.—Paragraph (4) of section 6103(p) of such Code is amended—

(1) by striking ''(19),'' each place it appears, and

(2) by striking ''or (17)'' each place it appears and inserting ''(17), or (19)''.

(c) CONFORMING AMENDMENT.—Paragraph (3) of section 6103(a) of such Code is amended by striking ''(19),''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to disclosures made after the date which is 12 months after the date of the enactment of this Act.

SEC. 1802. COMPARATIVE EFFECTIVENESS RESEARCH TRUST FUND; FINANCING FOR TRUST FUND.

(a) ESTABLISHMENT OF TRUST FUND.—

(1) IN GENERAL.—Subchapter A of chapter 98 of the Internal Revenue Code of 1986 (relating to trust fund code) is amended by adding at the end the following new section:

''SEC. 9511. HEALTH CARE COMPARATIVE EFFECTIVENESS RESEARCH TRUST FUND.

''(a) CREATION OF TRUST FUND.—There is established in the Treasury of the United States a trust fund to be known as the 'Health Care Comparative Effectiveness Research Trust Fund' (hereinafter in this section referred to as the 'CERTF'), consisting of such amounts as may be appropriated or credited to such Trust Fund as provided in this section and section 9602(b).

''(b) TRANSFERS TO FUND.—

''(1) IN GENERAL.—There are hereby appropriated to the Trust Fund the following:

''(A) For fiscal year 2010, $90,000,000.

''(B) For fiscal year 2011, $100,000,000.

''(C) For fiscal year 2012, $110,000,000.

''(D) For each fiscal year beginning with fiscal year 2013—

''(i) 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

''(ii) subject to subsection (c)(2), amounts determined by the Secretary of Health and Human Services to be equivalent to the fair share per capita amount computed under subsection (c)(1) for the fiscal year multiplied by the average number of individuals entitled to benefits under part A, or enrolled under part B, of title XVIII of the Social Security Act during such fiscal year.

''(2) ADMINISTRATIVE PROVISIONS.—

''(A) TRANSFERS FROM OTHER TRUST FUNDS.—The amounts appropriated by subparagraphs (A), (B), (C), and (D)(ii) of paragraph (1) shall be transferred from the Federal Hospital Insurance Trust Fund and from the Federal Supplementary Medical Insurance Trust Fund (established under section 1841 of such Act), and from the Medicare Prescription Drug Account within such Trust Fund, in proportion (as estimated by the Secretary) to the total expenditures during such fiscal year that are made under title XVIII of such Act from the respective trust fund or account.

''(B) APPROPRIATIONS NOT SUBJECT TO FISCAL YEAR LIMITATION.—The amounts appropriated by paragraph (1) shall not be subject to any fiscal year limitation.

''(C) PERIODIC TRANSFERS, ESTIMATES, AND ADJUSTMENTS.—Except as provided in subparagraph (A), the provisions of section 9601 shall apply to the amounts appropriated by paragraph (1).

''(c) FAIR SHARE PER CAPITA AMOUNT.—

''(1) COMPUTATION.—

''(A) IN GENERAL.—Subject to subparagraph (B), the fair share per capita amount under this paragraph for a fiscal year (beginning with fiscal year 2013) is an amount computed by the Secretary of Health and Human Services for such fiscal year that, when applied under this section and subchapter B of chapter 34 of the Internal Revenue Code of 1986, will result in revenues to the CERTF of $375,000,000 for the fiscal year.

''(B) ALTERNATIVE COMPUTATION.—

''(i) IN GENERAL.—If the Secretary is unable to compute the fair share per capita amount under subparagraph (A) for a fiscal year, the fair share per capita amount under this paragraph for the fiscal year shall be the default amount determined under clause (ii) for the fiscal year.

''(ii) DEFAULT AMOUNT.—The default amount under this clause for—

''(I) fiscal year 2013 is equal to $2; or

''(II) a subsequent year is equal to the default amount under this clause for the preceding fiscal year in-

creased by the annual percentage increase in the medical care component of the consumer price index (United States city average) for the 12-month period ending with April of the preceding fiscal year.

Any amount determined under subclause (II) shall be rounded to the nearest penny.

''(2) LIMITATION ON MEDICARE FUNDING.—In no case shall the amount transferred under subsection (b)(4)(B) for any fiscal year exceed $90,000,000.

''(d) EXPENDITURES FROM FUND.—

''(1) IN GENERAL.—Subject to paragraph (2), amounts in the CERTF are available, without the need for further appropriations and without fiscal year limitation, to the Secretary of Health and Human Services to carry out section 1181 of the Social Security Act.

''(2) ALLOCATION FOR COMMISSION.—The following amounts in the CERTF shall be available, without the need for further appropriations and without fiscal year limitation, to the Commission to carry out the activities of the Comparative Effective-

ness Research Commission established under section 1181(b) of the Social Security Act:

''(A) For fiscal year 2010, $7,000,000.

''(B) For fiscal year 2011, $9,000,000.

''(C) For each fiscal year beginning with 2012, 2.6 percent of the total amount appropriated to the CERTF under subsection (b) for the fiscal year.

''(e) NET REVENUES.—For purposes of this section, the term 'net revenues' means the amount estimated by the Secretary based on the excess of—

''(1) the fees received in the Treasury under subchapter B of chapter 34, over

''(2) the decrease in the tax imposed by chapter 1 resulting from the fees imposed by such subchapter.''.

(2) CLERICAL AMENDMENT.—The table of sections for such subchapter A is amended by adding at the end thereof the following new item:

''Sec. 9511. Health Care Comparative Effectiveness Research Trust Fund.''.

(b) FINANCING FOR FUND FROM FEES ON INSURED AND SELF-INSURED HEALTH PLANS.—

(1) GENERAL RULE.—Chapter 34 of the Internal Revenue Code of 1986 is amended by adding at the end the following new subchapter:

"Subchapter B—Insured and Self-Insured Health Plans

"SEC. 4375. HEALTH INSURANCE.

"(a) IMPOSITION OF FEE.—There is hereby imposed on each specified health insurance policy for each policy year a fee equal to the fair share per capita amount determined under section 9511(c)(1) multiplied by the average number of lives covered under the policy.

"(b) LIABILITY FOR FEE.—The fee imposed by subsection (a) shall be paid by the issuer of the policy.

"(c) SPECIFIED HEALTH INSURANCE POLICY.—For purposes of this section:

"(1) IN GENERAL.—Except as otherwise provided in this section, the term 'specified health insurance policy' means any accident or health insurance policy issued with respect to individuals residing in the United States.

"(2) EXEMPTION FOR CERTAIN POLICIES.—The term 'specified health insurance policy' does not include any insurance if substantially all of its coverage is of excepted benefits described in section 9832(c).

"(3) TREATMENT OF PREPAID HEALTH COVERAGE ARRANGEMENTS.—

''(A) IN GENERAL.—In the case of any arrangement described in subparagraph (B)—

''(i) such arrangement shall be treated as a specified health insurance policy, and

''(ii) the person referred to in such subparagraph shall be treated as the issuer.

''(B) DESCRIPTION OF ARRANGEMENTS.—An arrangement is described in this subparagraph if under such arrangement fixed payments or premiums are received as consideration for any person's agreement to provide or arrange for the provision of accident or health coverage to residents of the United States, regardless of how such coverage is provided or arranged to be provided.

''SEC. 4376. SELF-INSURED HEALTH PLANS.

''(a) IMPOSITION OF FEE.—In the case of any applicable self-insured health plan for each plan year, there is hereby imposed a fee equal to the fair share per capita amount determined under section 9511(c)(1) multiplied by the average number of lives covered under the plan.

''(b) LIABILITY FOR FEE.—

''(1) IN GENERAL.—The fee imposed by subsection (a) shall be paid by the plan sponsor.

''(2) PLAN SPONSOR.—For purposes of paragraph (1) the term 'plan sponsor' means—

''(A) the employer in the case of a plan established or maintained by a single employer,

''(B) the employee organization in the case of a plan established or maintained by an employee organization,

''(C) in the case of—

''(i) a plan established or maintained by 2 or more employers or jointly by 1 or more employers and 1 or more employee organizations,

''(ii) a multiple employer welfare arrangement, or

''(iii) a voluntary employees' beneficiary association described in section 501(c)(9),

the association, committee, joint board of trustees, or other similar group of representatives of the parties who establish or maintain the plan, or

''(D) the cooperative or association described in subsection (c)(2)(F) in the case of a plan established or maintained by such a cooperative or association.

''(c) APPLICABLE SELF-INSURED HEALTH PLAN.—For purposes of this section, the term 'applicable self-insured health plan' means any plan for providing accident or health coverage if—

''(1) any portion of such coverage is provided other than through an insurance policy, and

''(2) such plan is established or maintained—

''(A) by one or more employers for the benefit of their employees or former employees,

''(B) by one or more employee organizations for the benefit of their members or former members,

''(C) jointly by 1 or more employers and 1 or more employee organizations for the benefit of employees or former employees,

''(D) by a voluntary employees' beneficiary association described in section 501(c)(9),

''(E) by any organization described in section 501(c)(6), or

''(F) in the case of a plan not described in the preceding subparagraphs, by a multiple employer welfare arrangement (as defined in section 3(40) of Employee Retirement Income Security Act of 1974), a rural electric cooperative (as defined in section 3(40)(B)(iv) of such Act),

or a rural telephone cooperative association (as defined in section 3(40)(B)(v) of such Act).

"SEC. 4377. DEFINITIONS AND SPECIAL RULES.

"(a) DEFINITIONS.—For purposes of this subchapter—

"(1) ACCIDENT AND HEALTH COVERAGE.—The term 'accident and health coverage' means any coverage which, if provided by an insurance policy, would cause such policy to be a specified health insurance policy (as defined in section 4375(c)).

"(2) INSURANCE POLICY.—The term 'insurance policy' means any policy or other instrument whereby a contract of insurance is issued, renewed, or extended.

"(3) UNITED STATES.—The term 'United States' includes any possession of the United States.

"(b) TREATMENT OF GOVERNMENTAL ENTITIES.—

"(1) IN GENERAL.—For purposes of this subchapter—

"(A) the term 'person' includes any governmental entity, and

"(B) notwithstanding any other law or rule of law, governmental entities shall not be exempt from the fees imposed by this subchapter except as provided in paragraph (2).

''(2) TREATMENT OF EXEMPT GOVERNMENTAL PROGRAMS.—In the case of an exempt governmental program, no fee shall be imposed under section 4375 or section 4376 on any covered life under such program.

''(3) EXEMPT GOVERNMENTAL PROGRAM DEFINED.—For purposes of this subchapter, the term 'exempt governmental program' means—

''(A) any insurance program established under title XVIII of the Social Security Act,

''(B) the medical assistance program established by title XIX or XXI of the Social Security Act,

''(C) any program established by Federal law for providing medical care (other than through insurance policies) to individuals (or the spouses and dependents thereof) by reason of such individuals being—

''(i) members of the Armed Forces of the United States, or

''(ii) veterans, and

''(D) any program established by Federal law for providing medical care (other than through insurance policies) to members of In-

dian tribes (as defined in section 4(d) of the Indian Health Care Improvement Act).

''(c) TREATMENT AS TAX.—For purposes of subtitle F, the fees imposed by this subchapter shall be treated as if they were taxes.

''(d) NO COVER OVER TO POSSESSIONS.—Notwithstanding any other provision of law, no amount collected under this subchapter shall be covered over to any possession of the United States.''.

(2) CLERICAL AMENDMENTS.—

(A) Chapter 34 of such Code is amended by striking the chapter heading and inserting the following:

''CHAPTER 34—TAXES ON CERTAIN INSURANCE POLICIES

''SUBCHAPTER A. POLICIES ISSUED BY FOREIGN INSURERS

''SUBCHAPTER B. INSURED AND SELF-INSURED HEALTH PLANS

''Subchapter A—Policies Issued By Foreign Insurers''.

(B) The table of chapters for subtitle D of such Code is amended by striking the item relating to chapter 34 and inserting the following new item:

''CHAPTER 34—TAXES ON CERTAIN INSURANCE POLICIES''.

(3) EFFECTIVE DATE.—The amendments made by this subsection shall apply with respect to policies

and plans for portions of policy or plan years beginning on or after October 1, 2012.

TITLE IX—MISCELLANEOUS PROVISIONS

SEC. 1901. REPEAL OF TRIGGER PROVISION.

Subtitle A of title VIII of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173) is repealed and the provisions of law amended by such subtitle are restored as if such subtitle had never been enacted.

SEC. 1902. REPEAL OF COMPARATIVE COST ADJUSTMENT (CCA) PROGRAM.

Section 1860C–1 of the Social Security Act (42 U.S.C. 1395w–29), as added by section 241(a) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173), is repealed.

SEC. 1903. EXTENSION OF GAINSHARING DEMONSTRATION.

(a) IN GENERAL.—Subsection (d)(3) of section 5007 of the Deficit Reduction Act of 2005 (Public Law 109–171) is amended by inserting ''(or September 30, 2011, in the case of a demonstration project in operation as of October 1, 2008)'' after ''December 31, 2009''.

(b) FUNDING.—

(1) IN GENERAL.—Subsection (f)(1) of such section is amended by inserting ''and for fiscal year 2010, $1,600,000,'' after ''$6,000,000,''.

(2) AVAILABILITY.—Subsection (f)(2) of such section is amended by striking ''2010'' and inserting ''2014 or until expended''.

(c) REPORTS.—

(1) QUALITY IMPROVEMENT AND SAVINGS.—Subsection (e)(3) of such section is amended by striking ''December 1, 2008'' and inserting ''March 31, 2011''.

(2) FINAL REPORT.—Subsection (e)(4) of such section is amended by striking ''May 1, 2010'' and inserting ''March 31, 2013''.

SEC. 1904. GRANTS TO STATES FOR QUALITY HOME VISITATION PROGRAMS FOR FAMILIES WITH YOUNG CHILDREN AND FAMILIES EXPECTING CHILDREN.

Part B of title IV of the Social Security Act (42 U.S.C. 621–629i) is amended by adding at the end the following:

"Subpart 3—Support for Quality Home Visitation Programs

"SEC. 440. HOME VISITATION PROGRAMS FOR FAMILIES WITH YOUNG CHILDREN AND FAMILIES EXPECTING CHILDREN.

''(a) PURPOSE.—The purpose of this section is to improve the well-being, health, and development of children by enabling the establishment and expansion of high quality programs providing voluntary home visitation for families with young children and families expecting children.

''(b) GRANT APPLICATION.—A State that desires to receive a grant under this section shall submit to the Secretary for approval, at such time and in such manner as the Secretary may require, an application for the grant that includes the following:

''(1) DESCRIPTION OF HOME VISITATION PROGRAMS.—A description of the high quality programs of home visitation for families with young children and families expecting children that will be supported by a grant made to the State under this section, the outcomes the programs are intended to achieve, and the evidence supporting the effectiveness of the programs.

''(2) RESULTS OF NEEDS ASSESSMENT.—The results of a statewide needs assessment that describes—

''(A) the number, quality, and capacity of home visitation programs for families with young children and families expecting children in the State;

''(B) the number and types of families who are receiving services under the programs;

''(C) the sources and amount of funding provided to the programs;

''(D) the gaps in home visitation in the State, including identification of communities that are in high need of the services; and

''(E) training and technical assistance activities designed to achieve or support the goals of the programs.

''(3) ASSURANCES.—Assurances from the State that—

''(A) in supporting home visitation programs using funds provided under this section, the State shall identify and prioritize serving communities that are in high need of such services, especially communities with a high proportion of low-income families or a high incidence of child maltreatment;

''(B) the State will reserve 5 percent of the grant funds for training and technical assist-

ance to the home visitation programs using such funds;

''(C) in supporting home visitation programs using funds provided under this section, the State will promote coordination and collaboration with other home visitation programs (including programs funded under title XIX) and with other child and family services, health services, income supports, and other related assistance;

''(D) home visitation programs supported using such funds will, when appropriate, provide referrals to other programs serving children and families; and

''(E) the State will comply with subsection (i), and cooperate with any evaluation conducted under subsection (j).

''(4) OTHER INFORMATION.—Such other information as the Secretary may require.

''(c) ALLOTMENTS.—

''(1) INDIAN TRIBES.—From the amount reserved under subsection (l)(2) for a fiscal year, the Secretary shall allot to each Indian tribe that meets the requirement of subsection (d), if applicable, for the fiscal year the amount that bears the same ratio

to the amount so reserved as the number of children in the Indian tribe whose families have income that does not exceed 200 percent of the poverty line bears to the total number of children in such Indian tribes whose families have income that does not exceed 200 percent of the poverty line.

''(2) STATES AND TERRITORIES.—From the amount appropriated under subsection (m) for a fiscal year that remains after making the reservations required by subsection (l), the Secretary shall allot to each State that is not an Indian tribe and that meets the requirement of subsection (d), if applicable, for the fiscal year the amount that bears the same ratio to the remainder of the amount so appropriated as the number of children in the State whose families have income that does not exceed 200 percent of the poverty line bears to the total number of children in such States whose families have income that does not exceed 200 percent of the poverty line.

''(3) REALLOTMENTS.—The amount of any allotment to a State under a paragraph of this subsection for any fiscal year that the State certifies to the Secretary will not be expended by the State pursuant to this section shall be available for reallotment using the allotment methodology specified in

that paragraph. Any amount so reallotted to a State is deemed part of the allotment of the State under this subsection.

''(d) MAINTENANCE OF EFFORT.—Beginning with fiscal year 2011, a State meets the requirement of this subsection for a fiscal year if the Secretary finds that the aggregate expenditures by the State from State and local sources for programs of home visitation for families with young children and families expecting children for the then preceding fiscal year was not less than 100 percent of such aggregate expenditures for the then 2nd preceding fiscal year.

''(e) PAYMENT OF GRANT.—

''(1) IN GENERAL.—The Secretary shall make a grant to each State that meets the requirements of subsections (b) and (d), if applicable, for a fiscal year for which funds are appropriated under 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.

''(f) ELIGIBLE EXPENDITURES.—

''(1) IN GENERAL.—In this section, the term 'eligible expenditures'—

''(A) means expenditures to provide voluntary home visitation for as many families with young children (under the age of school entry) and families expecting children as practicable, through the implementation or expansion of high quality home visitation programs that—

''(i) adhere to clear evidence-based models of home visitation that have demonstrated positive effects on important program-determined child and parenting outcomes, such as reducing abuse and neglect and improving child health and development;

''(ii) employ well-trained and competent staff, maintain high quality super-

vision, provide for ongoing training and professional development, and show strong organizational capacity to implement such a program;

''(iii) establish appropriate linkages and referrals to other community resources and supports;

''(iv) monitor fidelity of program implementation to ensure that services are delivered according to the specified model; and

''(v) provide parents with—

''(I) knowledge of age-appropriate child development in cognitive, language, social, emotional, and motor domains (including knowledge of second language acquisition, in the case of English language learners);

''(II) knowledge of realistic expectations of age-appropriate child behaviors;

''(III) knowledge of health and wellness issues for children and parents;

''(IV) modeling, consulting, and coaching on parenting practices;

''(V) skills to interact with their child to enhance age-appropriate development;

''(VI) skills to recognize and seek help for issues related to health, developmental delays, and social, emotional, and behavioral skills; and

''(VII) activities designed to help parents become full partners in the education of their children;

''(B) includes expenditures for training, technical assistance, and evaluations related to the programs; and

''(C) does not include any expenditure with respect to which a State has submitted a claim for payment under any other provision of Federal law.

''(2) PRIORITY FUNDING FOR PROGRAMS WITH STRONGEST EVIDENCE.—

''(A) IN GENERAL.—The expenditures, described in paragraph (1), of a State for a fiscal year that are attributable to the cost of programs that do not adhere to a model of home

visitation with the strongest evidence of effectiveness shall not be considered eligible expenditures for the fiscal year to the extent that the total of the expenditures exceeds the applicable percentage for the fiscal year of the allotment of the State under subsection (c) for the fiscal year.

''(B) APPLICABLE PERCENTAGE DEFINED.—In subparagraph (A), the term 'applicable percentage' means, with respect to a fiscal year—

''(i) 60 percent for fiscal year 2010;

''(ii) 55 percent for fiscal year 2011;

''(iii) 50 percent for fiscal year 2012;

''(iv) 45 percent for fiscal year 2013;

or

''(v) 40 percent for fiscal year 2014.

''(g) NO USE OF OTHER FEDERAL FUNDS FOR STATE MATCH.—A State to which a grant is made under this section may not expend any Federal funds to meet the State share of the cost of an eligible expenditure for which the State receives a payment under this section.

''(h) WAIVER AUTHORITY.—

''(1) IN GENERAL.—The Secretary may waive or modify the application of any provision of this

section, other than subsection (b) or (f), to an Indian tribe if the failure to do so would impose an undue burden on the Indian tribe.

''(2) SPECIAL RULE.—An Indian tribe is deemed to meet the requirement of subsection (d) for purposes of subsections (c) and (e) if—

''(A) the Secretary waives the requirement; or

''(B) the Secretary modifies the requirement, and the Indian tribe meets the modified requirement.

''(i) STATE REPORTS.—Each State to which a grant is made under this section shall submit to the Secretary an annual report on the progress made by the State in addressing the purposes of this section. Each such report shall include a description of—

''(1) the services delivered by the programs that received funds from the grant;

''(2) the characteristics of each such program, including information on the service model used by the program and the performance of the program;

''(3) the characteristics of the providers of services through the program, including staff qualifications, work experience, and demographic characteristics;

''(4) the characteristics of the recipients of services provided through the program, including the number of the recipients, the demographic characteristics of the recipients, and family retention;

''(5) the annual cost of implementing the program, including the cost per family served under the program;

''(6) the outcomes experienced by recipients of services through the program;

''(7) the training and technical assistance provided to aid implementation of the program, and how the training and technical assistance contributed to the outcomes achieved through the program;

''(8) the indicators and methods used to monitor whether the program is being implemented as designed; and

''(9) other information as determined necessary by the Secretary.

''(j) EVALUATION.—

''(1) IN GENERAL.—The Secretary shall, by grant or contract, provide for the conduct of an independent evaluation of the effectiveness of home visitation programs receiving funds provided under this section, which shall examine the following:

''(A) The effect of home visitation programs on child and parent outcomes, including child maltreatment, child health and development, school readiness, and links to community services.

''(B) The effectiveness of home visitation programs on different populations, including the extent to which the ability of programs to improve outcomes varies across programs and populations.

''(2) REPORTS TO THE CONGRESS.—

''(A) INTERIM REPORT.—Within 3 years after the date of the enactment of this section, the Secretary shall submit to the Congress an interim report on the evaluation conducted pursuant to paragraph (1).

''(B) FINAL REPORT.—Within 5 years after the date of the enactment of this section, the Secretary shall submit to the Congress a final report on the evaluation conducted pursuant to paragraph (1).

''(k) ANNUAL REPORTS TO THE CONGRESS.—The Secretary shall submit annually to the Congress a report on the activities carried out using funds made available

under this section, which shall include a description of the following:

''(1) The high need communities targeted by States for programs carried out under this section.

''(2) The service delivery models used in the programs receiving funds provided under this section.

''(3) The characteristics of the programs, including—

''(A) the qualifications and demographic characteristics of program staff; and

''(B) recipient characteristics including the number of families served, the demographic characteristics of the families served, and family retention and duration of services.

''(4) The outcomes reported by the programs.

''(5) The research-based instruction, materials, and activities being used in the activities funded under the grant.

''(6) The training and technical activities, including on-going professional development, provided to the programs.

''(7) The annual costs of implementing the programs, including the cost per family served under the programs.

''(8) The indicators and methods used by States to monitor whether the programs are being been implemented as designed.

''(l) RESERVATIONS OF FUNDS.—From the amounts appropriated for a fiscal year under subsection (m), the Secretary shall reserve—

''(1) an amount equal to 5 percent of the amounts to pay the cost of the evaluation provided for in subsection (j), and the provision to States of training and technical assistance, including the dissemination of best practices in early childhood home visitation; and

''(2) after making the reservation required by paragraph (1), an amount equal to 3 percent of the amount so appropriated, to pay for grants to Indian tribes under this section.

''(m) APPROPRIATIONS.—Out of any money in the Treasury of the United States not otherwise appropriated, there is appropriated to the Secretary to carry out this section—

''(1) $50,000,000 for fiscal year 2010;

''(2) $100,000,000 for fiscal year 2011;

''(3) $150,000,000 for fiscal year 2012;

''(4) $200,000,000 for fiscal year 2013; and

''(5) $250,000,000 for fiscal year 2014.

''(n) INDIAN TRIBES TREATED AS STATES.—In this section, paragraphs (4), (5), and (6) of section 431(a) shall apply.''.

SEC. 1905. IMPROVED COORDINATION AND PROTECTION FOR DUAL ELIGIBLES.

Title XI of the Social Security Act is amended by inserting after section 1150 the following new section:

''IMPROVED COORDINATION AND PROTECTION FOR DUAL ELIGIBLES

''SEC. 1150A. (a) IN GENERAL.—The Secretary shall provide, through an identifiable office or program within the Centers for Medicare & Medicaid Services, for a focused effort to provide for improved coordination between Medicare and Medicaid and protection in the case of dual eligibles (as defined in subsection (g)). The office or program shall—

''(1) review Medicare and Medicaid policies related to enrollment, benefits, service delivery, payment, and grievance and appeals processes under parts A and B of title XVIII, under the Medicare Advantage program under part C of such title, and under title XIX;

''(2) identify areas of such policies where better coordination and protection could improve care and costs; and

''(3) issue guidance to States regarding improving such coordination and protection.

''(b) ELEMENTS.—The improved coordination and protection under this section shall include efforts—

''(1) to simplify access of dual eligibles to benefits and services under Medicare and Medicaid;

''(2) to improve care continuity for dual eligibles and ensure safe and effective care transitions;

''(3) to harmonize regulatory conflicts between Medicare and Medicaid rules with regard to dual eligibles; and

''(4) to improve total cost and quality performance under Medicare and Medicaid for dual eligibles.

''(c) RESPONSIBILITIES.—In carrying out this section, the Secretary shall provide for the following:

''(1) An examination of Medicare and Medicaid payment systems to develop strategies to foster more integrated and higher quality care.

''(2) Development of methods to facilitate access to post-acute and community-based services and to identify actions that could lead to better coordination of community-based care.

''(3) A study of enrollment of dual eligibles in the Medicare Savings Program (as defined in section 1144(c)(7)), under Medicaid, and in the low-income

subsidy program under section 1860D–14 to identify methods to more efficiently and effectively reach and enroll dual eligibles.

''(4) An assessment of communication strategies for dual eligibles to determine whether additional informational materials or outreach is needed, including an assessment of the Medicare website, 1–800–MEDICARE, and the Medicare handbook.

''(5) Research and evaluation of areas where service utilization, quality, and access to cost sharing protection could be improved and an assessment of factors related to enrollee satisfaction with services and care delivery.

''(6) Collection (and making available to the public) of data and a database that describe the eligibility, benefit and cost-sharing assistance available to dual eligibles by State.

''(7) Support for coordination of State and Federal contracting and oversight for dual coordination programs supportive of the goals described in subsection (b).

''(8) Support for State Medicaid agencies through the provision of technical assistance for Medicare and Medicaid coordination initiatives de-

signed to improve acute and long-term care for dual eligibles.

''(9) Monitoring total combined Medicare and Medicaid program costs in serving dual eligibles and making recommendations for optimizing total quality and cost performance across both programs.

''(10) Coordination of activities relating to Medicare Advantage plans under 1859(b)(6)(B)(ii) and Medicaid.

''(d) REPORTING.—The Office or program shall work with relevant State agencies and any appropriate quality measurement entities to improve and coordinate reporting requirements for Medicare and Medicaid. In addition, the Office or program shall seek to minimize duplication in reporting requirements, where appropriate, and to identify opportunities to combine assessment requirements, where appropriate. The Office or program shall seek to identify quality metrics and assessment requirements that facilitate comparisons of the quality of care received by beneficiaries enrolled in or entitled to benefits under fee-for-service Medicare, the Medicare Advantage program, fee-for-service Medicaid, and Medicaid managed care, and combinations thereof (including integrated Medicare-Medicaid programs for dual eligibles).

''(e) ENDORSEMENT.—The Secretary shall seek endorsement by the entity with a contract under section 1890(a) of quality measures and benchmarks developed under this section.

''(f) CONSULTATION WITH STAKEHOLDERS.—The Office or program shall consult with relevant stakeholders, including dual eligible beneficiaries representatives for dual eligible beneficiaries, health plans, providers, and relevant State agencies, in the development of policies related to integrated Medicare-Medicaid programs for dual eligibles.

''(g) PERIODIC REPORTS.—Not later than 1 year after the date of the enactment of this section and every 3 years thereafter the Secretary shall submit to Congress a report on progress in activities conducted under this section.

''(h) DEFINITIONS.—In this section:

''(1) DUAL ELIGIBLE.—The term 'dual eligible' means an individual who is dually eligible for benefits under title XVIII, and medical assistance under title XIX, including such individuals who are eligible for benefits under the Medicare Savings Program (as defined in section 1144(c)(7)).

''(2) MEDICARE; MEDICAID.—The terms 'Medicare' and 'Medicaid' mean the programs under titles XVIII and XIX, respectively.''.

SEC. 1906. ASSESSMENT OF MEDICARE COST-INTENSIVE DISEASES AND CONDITIONS.

(a) INITIAL ASSESSMENT.—

(1) IN GENERAL.—The Secretary of Health and Human Services shall conduct an assessment of the diseases and conditions that are the most cost-intensive for the Medicare program and, to the extent possible, assess the diseases and conditions that could become cost-intensive for Medicare in the future. In conducting the assessment, the Secretary shall include the input of relevant research agencies, including the National Institutes of Health, the Agency for Healthcare Research and Quality, the Food and Drug Administration, and the Centers for Medicare & Medicaid Services.

(2) REPORT.—Not later than January 1, 2011, the Secretary shall transmit a report to the Committees on Energy and Commerce, Ways and Means, and Appropriations of the House of Representatives and the Committees on Health, Education, Labor and Pensions, Finance, and Appropriations of the

Senate on the assessment conducted under paragraph (1). Such report shall—

(A) include the assessment of current and future trends of cost-intensive diseases and conditions described in such paragraph;

(B) address whether current research priorities are appropriately addressing current and future cost-intensive conditions so identified; and

(C) include recommendations concerning research in the Department of Health and Human Services that should be funded to improve the prevention, treatment, or cure of such cost-intensive diseases and conditions.

(b) UPDATES OF ASSESSMENT.—Not later than January 1, 2013, and biennially thereafter, the Secretary shall—

(1) review and update the assessment and recommendations described in subsection (a)(1); and

(2) submit a report described in subsection (a)(2) to the Committees specified in subsection (a)(2) on such updated assessment and recommendations.

SEC. 1907. ESTABLISHMENT OF CENTER FOR MEDICARE AND MEDICAID INNOVATION WITHIN CMS.

(a) IN GENERAL.—Title XI of the Social Security Act is amended by inserting after section 1115 the following new section:

''CENTER FOR MEDICARE AND MEDICAID INNOVATION

''SEC. 1115A. (a) CENTER FOR MEDICARE AND MEDICAID INNOVATION ESTABLISHED.—

''(1) IN GENERAL.—There is created within the Centers for Medicare & Medicaid Services a Center for Medicare and Medicaid Innovation (in this section referred to as the 'CMI') to carry out the duties described in this section. The purpose of the CMI is to test innovative payment and service delivery models to improve the coordination, quality, and efficiency of health care services provided to applicable individuals defined in paragraph (4)(A).

''(2) DEADLINE.—The Secretary shall ensure that the CMI is carrying out the duties described in this section by not later than January 1, 2011.

''(3) CONSULTATION.—In carrying out the duties under this section, the CMI shall consult representatives of relevant Federal agencies, clinical and analytical experts with expertise in medicine and health care management, and States. The CMI shall

use open door forums or other mechanisms to seek input from interested parties.

''(4) DEFINITIONS.—In this section:

''(A) APPLICABLE INDIVIDUAL.—The term 'applicable individual' means—

''(i) an individual who is enrolled under part B and entitled to benefits under part A of title XVIII;

''(ii) an individual who is eligible for medical assistance under title XIX; or

''(iii) an individual who meets the criteria of both clauses (i) and (ii).

''(B) APPLICABLE TITLE.—The term 'applicable title' means title XVIII, title XIX, or both.

''(b) TESTING OF MODELS (PHASE I).—

''(1) IN GENERAL.—The CMI shall test payment and service delivery models in accordance with selection criteria under paragraph (2) to determine the effect of applying such models under the applicable title (as defined in subsection (a)(4)(B)) on program expenditures under such titles and the quality of care received by individuals receiving benefits under such title.

''(2) SELECTION OF MODELS TO BE TESTED.—

''(A) IN GENERAL.—The Secretary shall give preference to testing models for which, as determined by the Administrator of the Centers for Medicare & Medicaid Services and using such input from outside the Centers as the Administrator determines appropriate, there is evidence that the model addresses a defined population for which there are deficits in care leading to poor clinical outcomes or potentially avoidable expenditures. The Administrator shall focus on models expected to reduce program costs under the applicable title while preserving or enhancing the quality of care received by individuals receiving benefits under such title.

''(B) APPLICATION TO OTHER DEMONSTRATIONS.—The Secretary shall operate the demonstration programs under sections 1222 and 1236 of the Affordable Health Care for America Act through the CMI in accordance with the rules applicable under this section, including those relating to evaluations, terminations, and expansions.

''(3) BUDGET NEUTRALITY.—

''(A) INITIAL PERIOD.—The Secretary shall not require, as a condition for testing a

model under paragraph (1), that the design of such model ensure that such model is budget neutral initially with respect to expenditures under the applicable title.

''(B) TERMINATION.—The Secretary shall terminate or modify the design and implementation of a model unless the Secretary determines (and the Chief Actuary of the Centers for Medicare & Medicaid Services, with respect to spending under the applicable title, certifies), after testing has begun, that the model is expected to—

''(i) improve the quality of care (as determined by the Administrator of the Centers for Medicare & Medicaid Services) without increasing spending under such title;

''(ii) reduce spending under such titles without reducing the quality of care; or

''(iii) do both.

Such termination may occur at any time after such testing has begun and before completion of the testing.

''(4) EVALUATION.—

''(A) IN GENERAL.—The Secretary shall conduct an evaluation of each model tested under this subsection. Such evaluation shall include an analysis of—

''(i) the quality of care furnished under the model, including through the use of patient-level outcomes measures; and

''(ii) the changes in spending under the applicable titles by reason of the model.

The Secretary shall make the results of each evaluation under this paragraph available to the public in a timely fashion.

''(B) MEASURE SELECTION.—To the extent feasible, the Secretary shall select measures under this paragraph that reflect national priorities for quality improvement and patient-centered care consistent with the measures developed under section 1192(c)(1).

''(5) TESTING PERIOD.—In no case shall a model be tested under this subsection for more than a 7-year period.

''(c) EXPANSION OF MODELS (PHASE II).—The Secretary may expand the duration and the scope of a model

that is being tested under subsection (b) (including implementation on a nationwide basis), to the extent determined appropriate by the Secretary, if—

''(1) the Secretary determines that such expansion is expected—

''(A) to improve the quality of patient care without increasing spending under the applicable titles;

''(B) to reduce spending under applicable titles without reducing the quality of care; or

''(C) to do both;

''(2) the Chief Actuary of the Centers for Medicare & Medicaid Services certifies that such expansion would reduce (or not result in any increase in) net program spending under applicable titles; and

''(3) the Secretary determines that such expansion would not deny or limit the coverage or provision of benefits under the applicable title for applicable individuals.

''(d) IMPLEMENTATION.—

''(1) WAIVER AUTHORITY.—The Secretary may waive such requirements of titles XI and XVIII and of sections 1902 and 1903(m) as may be necessary solely for purposes of carrying out this section with respect to testing models described in subsection (b).

''(2) LIMITATIONS ON REVIEW.—There shall be no administrative or judicial review under section 1869, section 1878, or otherwise of—

''(A) the selection of models for testing or expansion under this section;

''(B) the elements, parameters, scope, and duration of such models for testing or dissemination;

''(C) the termination or modification of the design and implementation of a model under subsection (b)(3)(B); and

''(D) determinations about expansion of the duration and scope of a model under subsection (c) including the determination that a model is not expected to meet criteria described in paragraphs (1) or (2) of such subsection.

''(3) ADMINISTRATION.—Chapter 35 of title 44, United States Code shall not apply to the testing and evaluation of models or expansion of such models under this section.

''(4) FUNDING FOR TESTING ITEMS AND SERVICES AND ADMINISTRATIVE COSTS.—

''(A) ADDITIONAL BENEFITS.—There shall be available until expended, equally divided from the Federal Supplementary Hospital In-

surance Trust Fund and Federal Supplementary Medical Insurance Trust Fund for payments for additional benefits for items and services under models tested under subsection (b) not otherwise covered under this title and applicable to benefits under this title, and for researching, designing, implementing, and evaluating such models, $350,000,000 for fiscal year 2010, $440,000,000 for fiscal year 2011, $550,000,000 for fiscal year 2012, and, for a subsequent fiscal year, the amount determined under this subparagraph for the preceding fiscal year increased by the annual percentage rate of increase in total expenditures under this title for the subsequent fiscal year as estimated in the latest available Annual Report of the Board of Trustees as described in section 1841(b)(2).

''(B) MEDICAID.—For administrative costs of the Centers for Medicare & Medicaid Services for administering this section with respect to title XIX, from any amounts in the Treasury not otherwise appropriated there are appropriated to the Secretary for the Centers for Medicare & Medicaid Services Program Man-

agement Account $25,000,000 for each fiscal year beginning with fiscal year 2010. Amounts appropriated under this subparagraph for a fiscal year shall be available until expended.

''(e) REPORT TO CONGRESS.—Beginning in 2012, and not less than once every other year thereafter, the Secretary shall submit to Congress a report on activities under this section. Each such report shall describe the payment models tested under subsection (b), including the number of individuals described in subsection (a)(4)(A)(i) and of individuals described in subsection (a)(4)(A)(ii) participating in such models and payments made under applicable titles for services on behalf of such individuals, any models chosen for expansion under subsection (c), and the results from evaluations under subsection (b)(4). In addition, each such report shall provide such recommendations as the Secretary believes are appropriate for legislative action to facilitate the development and expansion of successful payment models.''.

(b) MEDICAID CONFORMING AMENDMENT.—Section 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)), as amended by sections 1631(b), 1703(a), 1729, 1753, 1757(a), and 1759(a), is amended—

(1) in paragraph (78), by striking ''and'' at the end;

(2) in paragraph (79), by striking the period at the end and inserting ''; and''; and

(3) by inserting after paragraph (79) the following new paragraph:

''(80) provide for implementation of the payment models specified by the Secretary under section 1115A(c) for implementation on a nationwide basis unless the State demonstrates to the satisfaction of the Secretary that implementation would not be administratively feasible or appropriate to the health care delivery system of the State.''.

SEC. 1908. APPLICATION OF EMERGENCY SERVICES LAWS.

Nothing in this Act shall be construed to relieve any health care provider from providing emergency services as required by State or Federal law, including section 1867 of the Social Security Act (popularly known as ″EMTALA″).

SEC. 1909. DISREGARD UNDER THE SUPPLEMENTAL SECURITY INCOME PROGRAM OF COMPENSATION FOR PARTICIPATION IN CLINICAL TRIALS FOR RARE DISEASES OR CONDITIONS.

(a) INCOME DISREGARD.—Section 1612(b) of the Social Security Act (42 U.S.C. 1382a(b)) is amended—

(1) by striking ''and'' at the end of paragraph (24);

(2) by striking the period at the end of paragraph (25) and inserting ''; and''; and

(3) by adding at the end the following:

''(26) The first $2,000 per year received by such individual (or such spouse) for participation in a clinical trial to test a treatment for a rare disease or condition (within the meaning of section 5(b)(2) of the Orphan Drug Act (Public Law 97–414)), that—

''(A) has been reviewed and approved by an institutional review board that—

''(i) is established to protect the rights and welfare of human subjects participating in research; and

''(ii) meet the standards for such bodies set forth in part 46 of title 45, Code of Federal Regulations; and

''(B) meets the standards for protection of human subjects for clinical research (as set forth in such part).''.

(b) RESOURCE DISREGARD.—Section 1613(a) of such Act (42 U.S.C. 1382b(a)) is amended—

(1) by striking ''and'' at the end of paragraph (15);

(2) by striking the period at the end of paragraph (16) and inserting ''; and''; and

(3) by inserting after paragraph (16) the following:

''(17) the first $2,000 per year received by such individual (or such spouse) for participation in a clinical trial, as described in section 1612(b)(26).''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to benefits payable for calendar months beginning after the earlier of—

(1) the date the Commissioner of Social Security promulgates regulations to carry out the amendments; or

(2) the 180-day period that begins with the date of the enactment of this Act.

DIVISION C—PUBLIC HEALTH AND WORKFORCE DEVELOPMENT

SEC. 2001. TABLE OF CONTENTS; REFERENCES.

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

(b) REFERENCES.—Except as otherwise specified, whenever in this division an amendment is expressed in terms of an amendment to a section or other provision, the reference shall be considered to be made to a section

or other provision of the Public Health Service Act (42 U.S.C. 201 et seq.).

SEC. 2002. PUBLIC HEALTH INVESTMENT FUND.

(a) ESTABLISHMENT OF FUNDS.—

(1) IN GENERAL.—Subject to section 2003, there is hereby established in the Treasury a separate account to be known as the ''Public Health Investment Fund'' (referred to in this section and section 2003 as the ''Fund'').

(2) FUNDING.—

(A) There shall be deposited into the Fund—

(i) for fiscal year 2011, $4,600,000,000;

(ii) for fiscal year 2012, $5,600,000,000;

(iii) for fiscal year 2013, $6,900,000,000;

(iv) for fiscal year 2014, $7,800,000,000; and

(v) for fiscal year 2015, $9,000,000,000.

(B) Amounts deposited into the Fund shall be derived from general revenues of the Treasury only for the fiscal years set forth in this

section, and amounts appropriated from the Fund shall remain available until expended.

(b) AUTHORIZATION OF APPROPRIATIONS FROM THE FUND.—

(1) NEW FUNDING.—

(A) IN GENERAL.—Subject to section 2003, amounts in the Fund are authorized to be appropriated for carrying out activities under designated public health provisions.

(B) DESIGNATED PROVISIONS.—For purposes of this paragraph, the term ''designated public health provisions'' means the provisions for which amounts are authorized to be appropriated under section 330(s), 338(c), 338H–1, 799C, 872, or 3111 of the Public Health Service Act, as added by this division.

(2) BASELINE FUNDING.—

(A) IN GENERAL.—Amounts in the Fund are authorized to be appropriated (as described in paragraph (1)) for a fiscal year only if (excluding any amounts in or appropriated from the Fund)—

(i) the amounts specified in subparagraph (B) for the fiscal year involved are equal to or greater than the amounts spec-

ified in subparagraph (B) for fiscal year 2008; and

(ii) the amounts appropriated, out of the general fund of the Treasury, to the Prevention and Wellness Trust under section 3111(a)(1) of the Public Health Service Act, as added by this division, for the fiscal year involved are equal to or greater than the funds—

(I) appropriated under the heading ''Prevention and Wellness Fund'' in title VIII of division A of the American Recovery and Reinvestment Act of 2009 (Public Law 111–5); and

(II) allocated by the second proviso under such heading for evidence-based clinical and community-based prevention and wellness strategies.

(B) AMOUNTS SPECIFIED.—The amounts specified in this subparagraph, with respect to a fiscal year, are the amounts appropriated for the following:

(i) Community health centers (including funds appropriated under the authority

of section 330 of the Public Health Service Act (42 U.S.C. 254b)).

(ii) The National Health Service Corps Program (including funds appropriated under the authority of section 338 of such Act (42 U.S.C. 254k)).

(iii) The National Health Service Corps Scholarship and Loan Repayment Programs (including funds appropriated under the authority of section 338H of such Act (42 U.S.C. 254q)).

(iv) Primary care education programs (including funds appropriated under the authority of sections 736, 740, 741, and 747 of such Act (42 U.S.C. 293, 293d, and 293k)).

(v) Sections 761 and 770 of such Act (42 U.S.C. 294n and 295e).

(vi) Nursing workforce development (including funds appropriated under the authority of title VIII of such Act (42 U.S.C. 296 et seq.)).

(vii) The National Center for Health Statistics (including funds appropriated under the authority of sections 304, 306,

307, and 308 of such Act (42 U.S.C. 242b, 242k, 242l, and 242m)).

(viii) The Agency for Healthcare Research and Quality (including funds appropriated under the authority of title IX of such Act (42 U.S.C. 299 et seq.)).

SEC. 2003. DEFICIT NEUTRALITY.

(a) AVAILABILITY.—Funds appropriated or made available pursuant to sections 330(s), 338(c), 338H–1, 799C, 872, or 3111 of the Public Health Service Act, as added by this division, are only available for the purposes set forth in this Act. Appropriations shall not be available and are precluded from obligation for any other purpose.

(b) ESTIMATION OF BUDGETARY IMPACT.—For the purposes of estimating the spending effects of this Act, the authorization of appropriations from the Fund, to the extent amounts in the Fund are derived from the general revenues of the Treasury, shall be treated as new direct spending and attributed to this Act.

(c) BUDGETARY TREATMENT.—For the purposes of section 257 of the Balanced Budget and Emergency Deficit Control Act of 1985, the Fund, to the extent amounts in the Fund are derived from the general revenues of the Treasury, and not in excess of amounts subsequently appropriated from the Fund, shall be deemed to be included

on the list of appropriations referenced under section 250(c)(17) of that Act.

TITLE I—COMMUNITY HEALTH CENTERS

SEC. 2101. INCREASED FUNDING.

Section 330 of the Public Health Service Act (42 U.S.C. 254b) is amended—

(1) in subsection (r)(1)—

(A) in subparagraph (D), by striking ''and'' at the end;

(B) in subparagraph (E), by striking the period at the end and inserting ''; and''; and

(C) by inserting at the end the following:

''(F) such sums as may be necessary for each of fiscal years 2013 through 2015.''; and

(2) by inserting after subsection (r) the following:

''(s) ADDITIONAL FUNDING.—For the purpose of carrying out this section, in addition to any other amounts authorized to be appropriated for such purpose, there are authorized to be appropriated, out of any monies in the Public Health Investment Fund, the following:

''(1) For fiscal year 2011, $1,000,000,000.

''(2) For fiscal year 2012, $1,500,000,000.

''(3) For fiscal year 2013, $2,500,000,000.

''(4) For fiscal year 2014, $3,000,000,000.

''(5) For fiscal year 2015, $4,000,000,000.''.

TITLE II—WORKFORCE

Subtitle A—Primary Care Workforce

PART 1—NATIONAL HEALTH SERVICE CORPS

SEC. 2201. NATIONAL HEALTH SERVICE CORPS.

(a) FULFILLMENT OF OBLIGATED SERVICE REQUIREMENT THROUGH HALF-TIME SERVICE.—

(1) WAIVERS.—Subsection (i) of section 331 (42 U.S.C. 254d) is amended—

(A) in paragraph (1), by striking ''In carrying out subpart III'' and all that follows through the period and inserting ''In carrying out subpart III, the Secretary may, in accordance with this subsection, issue waivers to individuals who have entered into a contract for obligated service under the Scholarship Program or the Loan Repayment Program under which the individuals are authorized to satisfy the requirement of obligated service through providing clinical practice that is half-time.'';

(B) in paragraph (2)—

(i) in subparagraphs (A)(ii) and (B), by striking ''less than full time'' each place it appears and inserting ''half time'';

(ii) in subparagraphs (C) and (F), by striking ''less than full-time service'' each place it appears and inserting ''half-time service''; and

(iii) by amending subparagraphs (D) and (E) to read as follows:

''(D) the entity and the Corps member agree in writing that the Corps member will perform half-time clinical practice;

''(E) the Corps member agrees in writing to fulfill all of the service obligations under section 338C through half-time clinical practice and either—

''(i) double the period of obligated service that would otherwise be required; or

''(ii) in the case of contracts entered into under section 338B, accept a minimum service obligation of 2 years with an award amount equal to 50 percent of the amount that would otherwise be payable for full-time service; and''; and

(C) in paragraph (3), by striking ''In evaluating a demonstration project described in paragraph (1)'' and inserting ''In evaluating waivers issued under paragraph (1)''.

(2) DEFINITIONS.—Subsection (j) of section 331 (42 U.S.C. 254d) is amended by adding at the end the following:

''(5) The terms 'full time' and 'full-time' mean a minimum of 40 hours per week in a clinical practice, for a minimum of 45 weeks per year.

''(6) The terms 'half time' and 'half-time' mean a minimum of 20 hours per week (not to exceed 39 hours per week) in a clinical practice, for a minimum of 45 weeks per year.''.

(b) REAPPOINTMENT TO NATIONAL ADVISORY COUNCIL.—Section 337(b)(1) (42 U.S.C. 254j(b)(1)) is amended by striking ''Members may not be reappointed to the Council.''.

(c) LOAN REPAYMENT AMOUNT.—Section 338B(g)(2)(A) (42 U.S.C. 254l–1(g)(2)(A)) is amended by striking ''$35,000'' and inserting ''$50,000, plus, beginning with fiscal year 2012, an amount determined by the Secretary on an annual basis to reflect inflation,''.

(d) TREATMENT OF TEACHING AS OBLIGATED SERVICE.—Subsection (a) of section 338C (42 U.S.C. 254m)

is amended by adding at the end the following: ''The Secretary may treat teaching as clinical practice for up to 20 percent of such period of obligated service.''.

SEC. 2202. AUTHORIZATIONS OF APPROPRIATIONS.

(a) NATIONAL HEALTH SERVICE CORPS PROGRAM.—Section 338 (42 U.S.C. 254k) is amended—

(1) in subsection (a), by striking ''2012'' and inserting ''2015''; and

(2) by adding at the end the following:

''(c) For the purpose of carrying out this subpart, in addition to any other amounts authorized to be appropriated for such purpose, there are authorized to be appropriated, out of any monies in the Public Health Investment Fund, the following:

''(1) $63,000,000 for fiscal year 2011.

''(2) $66,000,000 for fiscal year 2012.

''(3) $70,000,000 for fiscal year 2013.

''(4) $73,000,000 for fiscal year 2014.

''(5) $77,000,000 for fiscal year 2015.''.

(b) SCHOLARSHIP AND LOAN REPAYMENT PROGRAMS.—Subpart III of part D of title III of the Public Health Service Act (42 U.S.C. 254l et seq.) is amended—

(1) in section 338H(a)—

(A) in paragraph (4), by striking ''and'' at the end;

(B) in paragraph (5), by striking the period at the end and inserting ''; and''; and

(C) by adding at the end the following:

''(6) for each of fiscal years 2013 through 2015, such sums as may be necessary.''; and

(2) by inserting after section 338H the following:

''SEC. 338H–1. ADDITIONAL FUNDING.

''For the purpose of carrying out this subpart, in addition to any other amounts authorized to be appropriated for such purpose, there are authorized to be appropriated, out of any monies in the Public Health Investment Fund, the following:

''(1) $254,000,000 for fiscal year 2011.

''(2) $266,000,000 for fiscal year 2012.

''(3) $278,000,000 for fiscal year 2013.

''(4) $292,000,000 for fiscal year 2014.

''(5) $306,000,000 for fiscal year 2015.''.

PART 2—PROMOTION OF PRIMARY CARE AND DENTISTRY

SEC. 2211. FRONTLINE HEALTH PROVIDERS.

Part D of title III (42 U.S.C. 254b et seq.) is amended by adding at the end the following:

"Subpart XI—Health Professional Needs Areas

"SEC. 340H. IN GENERAL.

''(a) PROGRAM.—The Secretary, acting through the Administrator of the Health Resources and Services Administration, shall establish a program, to be known as the Frontline Health Providers Loan Repayment Program, to address unmet health care needs in health professional needs areas through loan repayments under section 340I.

''(b) DESIGNATION OF HEALTH PROFESSIONAL NEEDS AREAS.—

''(1) IN GENERAL.—In this subpart, the term 'health professional needs area' means an area, population, or facility that is designated by the Secretary in accordance with paragraph (2).

''(2) DESIGNATION.—To be designated by the Secretary as a health professional needs area under this subpart:

''(A) In the case of an area, the area must be a rational area for the delivery of health services.

''(B) The area, population, or facility must have, in one or more health disciplines, specialties, or subspecialties for the population served, as determined by the Secretary—

''(i) insufficient capacity of health professionals; or

''(ii) high needs for health services, including services to address health disparities.

''(C) With respect to the delivery of primary health services, the area, population, or facility must not include a health professional shortage area (as designated under section 332), except that the area, population, or facility may include such a health professional shortage area in which there is an unmet need for such services.

''(c) ELIGIBILITY.—To be eligible to participate in the Program, an individual shall—

''(1) hold a degree in a course of study or program (approved by the Secretary) from a school defined in section 799B(1)(A) (other than a school of public health);

''(2) hold a degree in a course of study or program (approved by the Secretary) from a school or program defined in subparagraph (C), (D), or (E)(4) of section 799B(1), as designated by the Secretary;

''(3) be enrolled as a full-time student—

''(A) in a school or program defined in subparagraph (C), (D), or (E)(4) of section 799B(1), as designated by the Secretary, or a school described in paragraph (1); and

''(B) in the final year of a course of study or program, offered by such school or program and approved by the Secretary, leading to a degree in a discipline referred to in subparagraph (A) (other than a graduate degree in public health), (C), (D), or (E)(4) of section 799B(1);

''(4) be a practitioner described in section 1842(b)(18)(C) or 1848(k)(3)(B)(iii) or (iv) of the Social Security Act; or

''(5) be a practitioner in the field of respiratory therapy, medical technology, or radiologic technology.

''(d) DEFINITIONS.—In this subpart:

''(1) The term 'health disparities' has the meaning given to the term in section 3171.

''(2) The term 'primary health services' has the meaning given to such term in section 331(a)(3)(D).

''SEC. 340I. LOAN REPAYMENTS.

''(a) LOAN REPAYMENTS.—The Secretary, acting through the Administrator of the Health Resources and

Services Administration, shall enter into contracts with individuals under which—

''(1) the individual agrees—

''(A) to serve as a full-time primary health services provider or as a full-time or part-time provider of other health services for a period of time equal to 2 years or such longer period as the individual may agree to;

''(B) to serve in a health professional needs area in a health discipline, specialty, or a subspecialty for which the area, population, or facility is designated as a health professional needs area under section 340H; and

''(C) in the case of an individual described in section 340H(c)(3) who is in the final year of study and who has accepted employment as a primary health services provider or provider of other health services in accordance with subparagraphs (A) and (B), to complete the education or training and maintain an acceptable level of academic standing (as determined by the educational institution offering the course of study or training); and

''(2) the Secretary agrees to pay, for each year of such service, an amount on the principal and in-

terest of the undergraduate or graduate educational loans (or both) of the individual that is not more than 50 percent of the average award made under the National Health Service Corps Loan Repayment Program under subpart III in that year.

''(b) PRACTICE SETTING.—A contract entered into under this section shall allow the individual receiving the loan repayment to satisfy the service requirement described in subsection (a)(1) through employment in a solo or group practice, a clinic, an accredited public or private nonprofit hospital, or any other health care entity, as deemed appropriate by the Secretary.

''(c) APPLICATION OF CERTAIN PROVISIONS.—The provisions of subpart III of part D shall, except as inconsistent with this section, apply to the loan repayment program under this subpart in the same manner and to the same extent as such provisions apply to the National Health Service Corps Loan Repayment Program established under section 338B.

''(d) INSUFFICIENT NUMBER OF APPLICANTS.—If there are an insufficient number of applicants for loan repayments under this section to obligate all appropriated funds, the Secretary shall transfer the unobligated funds to the National Health Service Corps for the purpose of recruiting applicants and entering into contracts with indi-

viduals so as to ensure a sufficient number of participants in the National Health Service Corps for the following year.

"SEC. 340J. REPORT.

"The Secretary shall submit to the Congress an annual report on the program carried out under this subpart.

"SEC. 340K. ALLOCATION.

"Of the amount of funds obligated under this subpart each fiscal year for loan repayments—

"(1) 90 percent shall be for physicians and other health professionals providing primary health services; and

"(2) 10 percent shall be for health professionals not described in paragraph (1).".

SEC. 2212. PRIMARY CARE STUDENT LOAN FUNDS.

(a) IN GENERAL.—Section 735 (42 U.S.C. 292y) is amended—

(1) by redesignating subsection (f) as subsection (g); and

(2) by inserting after subsection (e) the following:

"(f) DETERMINATION OF FINANCIAL NEED.—The Secretary—

"(1) may require, or authorize a school or other entity to require, the submission of financial infor-

mation to determine the financial resources available to any individual seeking assistance under this subpart; and

''(2) shall take into account the extent to which such individual is financially independent in determining whether to require or authorize the submission of such information regarding such individual's family members.''.

(b) REVISED GUIDELINES.—The Secretary of Health and Human Services shall—

(1) strike the second sentence of section 57.206(b)(1) of title 42, Code of Federal Regulations; and

(2) make such other revisions to guidelines and regulations in effect as of the date of the enactment of this Act as may be necessary for consistency with the amendments made by paragraph (1).

SEC. 2213. TRAINING IN FAMILY MEDICINE, GENERAL INTERNAL MEDICINE, GENERAL PEDIATRICS, GERIATRICS, AND PHYSICIAN ASSISTANTS.

Section 747 (42 U.S.C. 293k) is amended—

(1) by amending the section heading to read as follows: ''**PRIMARY CARE TRAINING AND ENHANCEMENT**'';

(2) by redesignating subsection (e) as subsection (g); and

(3) by striking subsections (a) through (d) and inserting the following:

''(a) PROGRAM.—The Secretary shall establish a primary care training and capacity building program consisting of awarding grants and contracts under subsections (b) and (c).

''(b) SUPPORT AND DEVELOPMENT OF PRIMARY CARE TRAINING PROGRAMS.—

''(1) IN GENERAL.—The Secretary shall make grants to, or enter into contracts with, eligible entities—

''(A) to plan, develop, operate, or participate in an accredited professional training program, including an accredited residency or internship program, in the field of family medicine, general internal medicine, general pediatrics, or geriatrics for medical students, interns, residents, or practicing physicians;

''(B) to provide financial assistance in the form of traineeships and fellowships to medical students, interns, residents, or practicing physicians, who are participants in any such program, and who plan to specialize or work in

family medicine, general internal medicine, general pediatrics, or geriatrics;

''(C) to plan, develop, operate, or participate in an accredited program for the training of physicians who plan to teach in family medicine, general internal medicine, general pediatrics, or geriatrics training programs including in community-based settings;

''(D) to provide financial assistance in the form of traineeships and fellowships to practicing physicians who are participants in any such programs and who plan to teach in a family medicine, general internal medicine, general pediatrics, or geriatrics training program; and

''(E) to plan, develop, operate, or participate in an accredited program for physician assistant education, and for the training of individuals who plan to teach in programs to provide such training.

''(2) ELIGIBILITY.—To be eligible for a grant or contract under paragraph (1), an entity shall be—

''(A) an accredited school of medicine or osteopathic medicine, public or nonprofit private

hospital, or physician assistant training program;

''(B) a public or private nonprofit entity; or

''(C) a consortium of 2 or more entities described in subparagraphs (A) and (B).

''(c) CAPACITY BUILDING IN PRIMARY CARE.—

''(1) IN GENERAL.—The Secretary shall make grants to or enter into contracts with eligible entities to establish, maintain, or improve—

''(A) academic administrative units (including departments, divisions, or other appropriate units) in the specialties of family medicine, general internal medicine, general pediatrics, or geriatrics; or

''(B) programs that improve clinical teaching in such specialties.

''(2) ELIGIBILITY.—To be eligible for a grant or contract under paragraph (1), an entity shall be an accredited school of medicine or osteopathic medicine.

''(d) PREFERENCE.—In awarding grants or contracts under this section, the Secretary shall give preference to entities that have a demonstrated record of at least one of the following:

''(1) Training a high or significantly improved percentage of health professionals who provide primary care.

''(2) Training individuals who are from disadvantaged backgrounds (including racial and ethnic minorities underrepresented among primary care professionals).

''(3) A high rate of placing graduates in practice settings having the principal focus of serving in underserved areas or populations experiencing health disparities (including serving patients eligible for medical assistance under title XIX of the Social Security Act or for child health assistance under title XXI of such Act or those with special health care needs).

''(4) Supporting teaching programs that address the health care needs of vulnerable populations.

''(e) REPORT.—The Secretary shall submit to the Congress an annual report on the program carried out under this section.

''(f) DEFINITION.—In this section, the term 'health disparities' has the meaning given the term in section 3171.''.

SEC. 2214. TRAINING OF MEDICAL RESIDENTS IN COMMUNITY-BASED SETTINGS.

Title VII (42 U.S.C. 292 et seq.) is amended—

(1) by redesignating section 748 as 749A; and

(2) by inserting after section 747 the following:

"SEC. 748. TRAINING OF MEDICAL RESIDENTS IN COMMUNITY-BASED SETTINGS.

''(a) PROGRAM.—The Secretary shall establish a program for the training of medical residents in community-based settings consisting of awarding grants and contracts under this section.

''(b) DEVELOPMENT AND OPERATION OF COMMUNITY-BASED PROGRAMS.—The Secretary shall make grants to, or enter into contracts with, eligible entities—

''(1) to plan and develop a new primary care residency training program, which may include—

''(A) planning and developing curricula;

''(B) recruiting and training residents and faculty; and

''(C) other activities designated to result in accreditation of such a program; or

''(2) to operate or participate in an established primary care residency training program, which may include—

''(A) planning and developing curricula;

''(B) recruitment and training of residents; and

''(C) retention of faculty.

''(c) ELIGIBLE ENTITY.—To be eligible to receive a grant or contract under subsection (b), an entity shall—

''(1) be designated as a recipient of payment for the direct costs of medical education under section 1886(k) of the Social Security Act;

''(2) be designated as an approved teaching health center under section 1502(d) of the Affordable Health Care for America Act and continuing to participate in the demonstration project under such section;

''(3) be an applicant for designation described in paragraph (1) or (2) and have demonstrated to the Secretary appropriate involvement of an accredited teaching hospital to carry out the inpatient responsibilities associated with a primary care residency training program; or

''(4) be eligible to be designated as described in paragraph (1) or (2), not be an applicant as described in paragraph (3), and have demonstrated appropriate involvement of an accredited teaching hospital to carry out the inpatient responsibilities asso-

ciated with a primary care residency training program.

''(d) PREFERENCES.—In awarding grants and contracts under paragraph (1) or (2) of subsection (b), the Secretary shall give preference to entities that—

''(1) support teaching programs that address the health care needs of vulnerable populations; or

''(2) are a Federally qualified health center (as defined in section 1861(aa)(4) of the Social Security Act) or a rural health clinic (as defined in section 1861(aa)(2) of such Act).

''(e) ADDITIONAL PREFERENCES FOR ESTABLISHED PROGRAMS.—In awarding grants and contracts under subsection (b)(2), the Secretary shall give preference to entities that have a demonstrated record of training—

''(1) a high or significantly improved percentage of health professionals who provide primary care;

''(2) individuals who are from disadvantaged backgrounds (including racial and ethnic minorities underrepresented among primary care professionals); or

''(3) individuals who practice in settings having the principal focus of serving underserved areas or populations experiencing health disparities (including serving patients eligible for medical assistance under

title XIX of the Social Security Act or for child health assistance under title XXI of such Act or those with special health care needs).

''(f) PERIOD OF AWARDS.—

''(1) IN GENERAL.—The period of a grant or contract under this section—

''(A) shall not exceed 3 years for awards under subsection (b)(1); and

''(B) shall not exceed 5 years for awards under subsection (b)(2).

''(2) SPECIAL RULES.—

''(A) An award of a grant or contract under subsection (b)(1) shall not be renewed.

''(B) The period of a grant or contract awarded to an entity under subsection (b)(2) shall not overlap with the period of any grant or contact awarded to the same entity under subsection (b)(1).

''(g) REPORT.—The Secretary shall submit to the Congress an annual report on the program carried out under this section.

''(h) DEFINITIONS.—In this section:

''(1) HEALTH DISPARITIES.—The term 'health disparities' has the meaning given the term in section 3171.

''(2) PRIMARY CARE RESIDENT.—The term 'primary care resident' has the meaning given the term in section 1886(h)(5)(H) of the Social Security Act.

''(3) PRIMARY CARE RESIDENCY TRAINING PROGRAM.—The term 'primary care residency training program' means an approved medical residency training program described in section 1886(h)(5)(A) of the Social Security Act for primary care residents that is—

''(A) in the case of entities seeking awards under subsection (b)(1), actively applying to be accredited by the Accreditation Council for Graduate Medical Education or the American Osteopathic Association; or

''(B) in the case of entities seeking awards under subsection (b)(2), so accredited.

''(i) ALLOCATION OF FUNDS.—Of the amount appropriated pursuant to section 799C(a) for a fiscal year, not more than 17 percent of such amount shall be made available to carry out this section.''.

SEC. 2215. TRAINING FOR GENERAL, PEDIATRIC, AND PUBLIC HEALTH DENTISTS AND DENTAL HYGIENISTS.

Title VII (42 U.S.C. 292 et seq.) is amended—

(1) in section 791(a)(1), by striking ''747 and 750'' and inserting ''747, 749, and 750''; and

(2) by inserting after section 748, as added, the following:

''SEC. 749. TRAINING FOR GENERAL, PEDIATRIC, AND PUBLIC HEALTH DENTISTS AND DENTAL HYGIENISTS.

''(a) PROGRAM.—The Secretary shall establish a training program for oral health professionals consisting of awarding grants and contracts under this section.

''(b) SUPPORT AND DEVELOPMENT OF ORAL HEALTH TRAINING PROGRAMS.—The Secretary shall make grants to, or enter into contracts with, eligible entities—

''(1) to plan, develop, operate, or participate in an accredited professional training program for oral health professionals;

''(2) to provide financial assistance to oral health professionals who are in need thereof, who are participants in any such program, and who plan to work in general, pediatric, or public health dentistry, or dental hygiene;

''(3) to plan, develop, operate, or participate in a program for the training of oral health profes-

sionals who plan to teach in general, pediatric, or public health dentistry, or dental hygiene;

''(4) to provide financial assistance in the form of traineeships and fellowships to oral health professionals who plan to teach in general, pediatric, or public health dentistry or dental hygiene;

''(5) to establish, maintain, or improve—

''(A) academic administrative units (including departments, divisions, or other appropriate units) in the specialties of general, pediatric, or public health dentistry; or

''(B) programs that improve clinical teaching in such specialties;

''(6) to plan, develop, operate, or participate in predoctoral and postdoctoral training in general, pediatric, or public health dentistry programs;

''(7) to plan, develop, operate, or participate in a loan repayment program for full-time faculty in a program of general, pediatric, or public health dentistry; and

''(8) to provide technical assistance to pediatric dental training programs in developing and implementing instruction regarding the oral health status, dental care needs, and risk-based clinical disease

management of all pediatric populations with an emphasis on underserved children.

''(c) ELIGIBILITY.—To be eligible for a grant or contract under this section, an entity shall be—

''(1) an accredited school of dentistry, training program in dental hygiene, or public or nonprofit private hospital;

''(2) a training program in dental hygiene at an accredited institution of higher education;

''(3) a public or private nonprofit entity; or

''(4) a consortium of—

''(A) 1 or more of the entities described in paragraphs (1) through (3); and

''(B) an accredited school of public health.

''(d) PREFERENCE.—In awarding grants or contracts under this section, the Secretary shall give preference to entities that have a demonstrated record of at least one of the following:

''(1) Training a high or significantly improved percentage of oral health professionals who practice general, pediatric, or public health dentistry.

''(2) Training individuals who are from disadvantaged backgrounds (including racial and ethnic minorities underrepresented among oral health professionals).

''(3) A high rate of placing graduates in practice settings having the principal focus of serving in underserved areas or populations experiencing health disparities (including serving patients eligible for medical assistance under title XIX of the Social Security Act or for child health assistance under title XXI of such Act or those with special health care needs).

''(4) Supporting teaching programs that address the oral health needs of vulnerable populations.

''(5) Providing instruction regarding the oral health status, oral health care needs, and risk-based clinical disease management of all pediatric populations with an emphasis on underserved children.

''(e) REPORT.—The Secretary shall submit to the Congress an annual report on the program carried out under this section.

''(f) DEFINITIONS.—In this section:

''(1) The term 'health disparities' has the meaning given the term in section 3171.

''(2) The term 'oral health professional' means an individual training or practicing—

''(A) in general dentistry, pediatric dentistry, public health dentistry, or dental hygiene; or

''(B) another oral health specialty, as deemed appropriate by the Secretary.''.

SEC. 2216. AUTHORIZATION OF APPROPRIATIONS.

(a) IN GENERAL.—Part F of title VII (42 U.S.C. 295j et seq.) is amended by adding at the end the following:

''SEC. 799C. FUNDING THROUGH PUBLIC HEALTH INVESTMENT FUND.

''(a) PROMOTION OF PRIMARY CARE AND DENTISTRY.—For the purpose of carrying out subpart XI of part D of title III and sections 747, 748, and 749, in addition to any other amounts authorized to be appropriated for such purpose, there are authorized to be appropriated, out of any monies in the Public Health Investment Fund, the following:

''(1) $240,000,000 for fiscal year 2011.

''(2) $253,000,000 for fiscal year 2012.

''(3) $265,000,000 for fiscal year 2013.

''(4) $278,000,000 for fiscal year 2014.

''(5) $292,000,000 for fiscal year 2015.''.

(b) EXISTING AUTHORIZATION OF APPROPRIATIONS.—Subsection (g)(1), as so redesignated, of section

747 (42 U.S.C. 293k) is amended by striking ''2002'' and inserting ''2015''.

SEC. 2217. STUDY ON EFFECTIVENESS OF SCHOLARSHIPS AND LOAN REPAYMENTS.

(a) STUDY.—The Comptroller General of the United States shall conduct a study to determine the effectiveness of scholarship and loan repayment programs under subparts III and XI of part D of title III of the Public Health Service Act, as amended or added by sections 2201 and 2211, including whether scholarships or loan repayments are more effective in—

(1) incentivizing physicians, and other providers, to pursue careers in primary care specialties;

(2) retaining such primary care providers; and

(3) encouraging such primary care providers to practice in underserved areas.

(b) REPORT.—Not later than 12 months after the date of the enactment of this Act, the Comptroller General shall submit to the Congress a report on the results of the study under subsection (a).

Subtitle B—Nursing Workforce

SEC. 2221. AMENDMENTS TO PUBLIC HEALTH SERVICE ACT.

(a) DEFINITIONS.—Section 801 (42 U.S.C. 296 et seq.) is amended—

(1) in paragraph (1), by inserting ''nurse-managed health centers,'' after ''nursing centers,''; and

(2) by adding at the end the following:

''(16) NURSE-MANAGED HEALTH CENTER.—The term 'nurse-managed health center'—

''(A) means a nurse-practice arrangement, managed by one or more advanced practice nurses, that provides primary care or wellness services to underserved or vulnerable populations and is associated with an accredited school of nursing, Federally qualified health center, or independent nonprofit health or social services agency; and

''(B) shall not be construed as changing State law requirements applicable to an advanced practice nurse or the authorized scope of practice of such a nurse.''.

(b) GRANTS FOR HEALTH PROFESSIONS EDUCATION.—Title VIII (42 U.S.C. 296 et seq.) is amended by striking section 807.

(c) REPORTS.—Part A of title VIII (42 U.S.C. 296 et seq.) is amended by adding at the end the following:

"SEC. 809. REPORTS.

"The Secretary shall submit to the Congress a separate annual report on the activities carried out under each of sections 811, 821, 836, 846A, and 861.".

(d) ADVANCED EDUCATION NURSING GRANTS.—Section 811(f) (42 U.S.C. 296j(f)) is amended—

(1) by striking paragraph (2);

(2) by redesignating paragraph (3) as paragraph (2); and

(3) in paragraph (2), as so redesignated, by striking "that agrees" and all that follows through the end and inserting: "that agrees to expend the award—

"(A) to train advanced education nurses who will practice in health professional shortage areas designated under section 332; or

"(B) to increase diversity among advanced education nurses.".

(e) NURSE EDUCATION, PRACTICE, AND RETENTION GRANTS.—Section 831 (42 U.S.C. 296p) is amended—

(1) in subsection (b), by amending paragraph (3) to read as follows:

"(3) providing coordinated care, quality care, and other skills needed to practice nursing; or"; and

(2) by striking subsection (e) and redesignating subsections (f) through (h) as subsections (e) through (g), respectively.

(f) STUDENT LOANS.—Subsection (a) of section 836 (42 U.S.C. 297b) is amended—

(1) by striking ''$2,500'' and inserting ''$3,300'';

(2) by striking ''$4,000'' and inserting ''$5,200'';

(3) by striking ''$13,000'' and inserting ''$17,000''; and

(4) by adding at the end the following: ''Beginning with fiscal year 2012, the dollar amounts specified in this subsection shall be adjusted by an amount determined by the Secretary on an annual basis to reflect inflation.''.

(g) LOAN REPAYMENT.—Section 846 (42 U.S.C. 297n) is amended—

(1) in subsection (a), by amending paragraph (3) to read as follows:

''(3) who enters into an agreement with the Secretary to serve for a period of not less than 2 years—

''(A) as a nurse at a health care facility with a critical shortage of nurses; or

''(B) as a faculty member at an accredited school of nursing;''; and

(2) in subsection (g)(1), by striking ''to provide health services'' each place it appears and inserting ''to provide health services or serve as a faculty member''.

(h) NURSE FACULTY LOAN PROGRAM.—Paragraph (2) of section 846A(c) (42 U.S.C. 297n–1(c)) is amended by striking ''$30,000'' and all that follows through the semicolon and inserting ''$35,000, plus, beginning with fiscal year 2012, an amount determined by the Secretary on an annual basis to reflect inflation;''.

(i) PUBLIC SERVICE ANNOUNCEMENTS.—Title VIII (42 U.S.C. 296 et seq.) is amended by striking part H.

(j) TECHNICAL AND CONFORMING AMENDMENTS.—Title VIII (42 U.S.C. 296 et seq.) is amended—

(1) by moving section 810 (relating to prohibition against discrimination by schools on the basis of sex) so that it follows section 809, as added by subsection (c);

(2) in sections 835, 836, 838, 840, and 842, by striking the term ''this subpart'' each place it appears and inserting ''this part'';

(3) in section 836(h), by striking the last sentence;

(4) in section 836, by redesignating subsection (l) as subsection (k);

(5) in section 839, by striking ''839'' and all that follows through ''(a)'' and inserting ''839. (a)'';

(6) in section 835(b), by striking ''841'' each place it appears and inserting ''871'';

(7) by redesignating section 841 as section 871, moving part F to the end of the title, and redesignating such part as part H;

(8) in part G—

(A) by redesignating section 845 as section 851; and

(B) by redesignating part G as part F; and

(9) in part I—

(A) by redesignating section 855 as section 861; and

(B) by redesignating part I as part G.

(k) FUNDING.—

(1) IN GENERAL.—Part H, as redesignated, of title VIII is amended by adding at the end the following:

''SEC. 872. FUNDING THROUGH PUBLIC HEALTH INVESTMENT FUND.

''For the purpose of carrying out this title, in addition to any other amounts authorized to be appropriated

for such purpose, there are authorized to be appropriated, out of any monies in the Public Health Investment Fund, the following:

''(1) $115,000,000 for fiscal year 2011.

''(2) $122,000,000 for fiscal year 2012.

''(3) $127,000,000 for fiscal year 2013.

''(4) $134,000,000 for fiscal year 2014.

''(5) $140,000,000 for fiscal year 2015.''.

(2) EXISTING AUTHORIZATIONS OF APPROPRIATIONS.—

(A) SECTIONS 831, 846, 846A, AND 861.—Sections 831(g) (as so redesignated), 846(i)(1) (42 U.S.C. 297n(i)(1)), 846A(f) (42 U.S.C. 297n–1(f)), and 861(e) (as so redesignated) are amended by striking ''2007'' each place it appears and inserting ''2015''.

(B) SECTION 871.—Section 871, as so redesignated by subsection (j), is amended to read as follows:

''SEC. 871. FUNDING.

''For the purpose of carrying out parts B, C, and D (subject to section 851(g)), there are authorized to be appropriated such sums as may be necessary for each fiscal year through fiscal year 2015.''.

Subtitle C—Public Health Workforce

SEC. 2231. PUBLIC HEALTH WORKFORCE CORPS.

Part D of title III (42 U.S.C. 254b et seq.), as amended by section 2211, is amended by adding at the end the following:

"Subpart XII—Public Health Workforce

"SEC. 340L. PUBLIC HEALTH WORKFORCE CORPS.

''(a) ESTABLISHMENT.—There is established, within the Service, the Public Health Workforce Corps (in this subpart referred to as the 'Corps'), for the purpose of ensuring an adequate supply of public health professionals throughout the Nation. The Corps shall consist of—

''(1) such officers of the Regular and Reserve Corps of the Service as the Secretary may designate;

''(2) such civilian employees of the United States as the Secretary may appoint; and

''(3) such other individuals who are not employees of the United States.

''(b) ADMINISTRATION.—Except as provided in subsection (c), the Secretary shall carry out this subpart acting through the Administrator of the Health Resources and Services Administration.

''(c) PLACEMENT AND ASSIGNMENT.—The Secretary, acting through the Director of the Centers for Disease

Control and Prevention, shall develop a methodology for placing and assigning Corps participants as public health professionals. Such methodology may allow for placing and assigning such participants in State, local, and tribal health departments and Federally qualified health centers (as defined in section 1861(aa)(4) of the Social Security Act).

''(d) APPLICATION OF CERTAIN PROVISIONS.—The provisions of subpart II shall, except as inconsistent with this subpart, apply to the Public Health Workforce Corps in the same manner and to the same extent as such provisions apply to the National Health Service Corps established under section 331.

''(e) REPORT.—The Secretary shall submit to the Congress an annual report on the programs carried out under this subpart.

''SEC. 340M. PUBLIC HEALTH WORKFORCE SCHOLARSHIP PROGRAM.

''(a) ESTABLISHMENT.—The Secretary shall establish the Public Health Workforce Scholarship Program (referred to in this section as the 'Program') for the purpose described in section 340L(a).

''(b) ELIGIBILITY.—To be eligible to participate in the Program, an individual shall—

''(1)(A) be accepted for enrollment, or be enrolled, as a full-time or part-time student in a course of study or program (approved by the Secretary) at an accredited graduate school or program of public health; or

''(B) have demonstrated expertise in public health and be accepted for enrollment, or be enrolled, as a full-time or part-time student in a course of study or program (approved by the Secretary) at—

''(i) an accredited graduate school or program of nursing; health administration, management, or policy; preventive medicine; laboratory science; veterinary medicine; or dental medicine; or

''(ii) another accredited graduate school or program, as deemed appropriate by the Secretary;

''(2) be eligible for, or hold, an appointment as a commissioned officer in the Regular or Reserve Corps of the Service or be eligible for selection for civilian service in the Corps; and

''(3) sign and submit to the Secretary a written contract (described in subsection (c)) to serve full-time as a public health professional, upon the com-

pletion of the course of study or program involved, for the period of obligated service described in subsection (c)(2)(E).

''(c) CONTRACT.—The written contract between the Secretary and an individual under subsection (b)(3) shall contain—

''(1) an agreement on the part of the Secretary that the Secretary will—

''(A) provide the individual with a scholarship for a period of years (not to exceed 4 academic years) during which the individual shall pursue an approved course of study or program to prepare the individual to serve in the public health workforce; and

''(B) accept (subject to the availability of appropriated funds) the individual into the Corps;

''(2) an agreement on the part of the individual that the individual will—

''(A) accept provision of such scholarship to the individual;

''(B) maintain full-time or part-time enrollment in the approved course of study or program described in subsection (b)(1) until the in-

dividual completes that course of study or program;

''(C) while enrolled in the approved course of study or program, maintain an acceptable level of academic standing (as determined by the educational institution offering such course of study or program);

''(D) if applicable, complete a residency or internship; and

''(E) serve full-time as a public health professional for a period of time equal to the greater of—

''(i) 1 year for each academic year for which the individual was provided a scholarship under the Program; or

''(ii) 2 years; and

''(3) an agreement by both parties as to the nature and extent of the scholarship assistance, which may include—

''(A) payment of reasonable educational expenses of the individual, including tuition, fees, books, equipment, and laboratory expenses; and

''(B) payment of a stipend of not more than $1,269 (plus, beginning with fiscal year 2012, an amount determined by the Secretary

on an annual basis to reflect inflation) per month for each month of the academic year involved, with the dollar amount of such a stipend determined by the Secretary taking into consideration whether the individual is enrolled full-time or part-time.

''(d) APPLICATION OF CERTAIN PROVISIONS.—The provisions of subpart III shall, except as inconsistent with this subpart, apply to the scholarship program under this section in the same manner and to the same extent as such provisions apply to the National Health Service Corps Scholarship Program established under section 338A.

''SEC. 340N. PUBLIC HEALTH WORKFORCE LOAN REPAYMENT PROGRAM.

''(a) ESTABLISHMENT.—The Secretary shall establish the Public Health Workforce Loan Repayment Program (referred to in this section as the 'Program') for the purpose described in section 340L(a).

''(b) ELIGIBILITY.—To be eligible to participate in the Program, an individual shall—

''(1)(A) have a graduate degree from an accredited school or program of public health;

''(B) have demonstrated expertise in public health and have a graduate degree in a course of

study or program (approved by the Secretary) from—

''(i) an accredited school or program of nursing; health administration, management, or policy; preventive medicine; laboratory science; veterinary medicine; or dental medicine; or

''(ii) another accredited school or program approved by the Secretary; or

''(C) be enrolled as a full-time or part-time student in the final year of a course of study or program (approved by the Secretary) offered by a school or program described in subparagraph (A) or (B), leading to a graduate degree;

''(2) be eligible for, or hold, an appointment as a commissioned officer in the Regular or Reserve Corps of the Service or be eligible for selection for civilian service in the Corps;

''(3) if applicable, complete a residency or internship; and

''(4) sign and submit to the Secretary a written contract (described in subsection (c)) to serve full-time as a public health professional for the period of obligated service described in subsection (c)(2).

''(c) CONTRACT.—The written contract between the Secretary and an individual under subsection (b)(4) shall contain—

''(1) an agreement by the Secretary to repay on behalf of the individual loans incurred by the individual in the pursuit of the relevant public health workforce educational degree in accordance with the terms of the contract;

''(2) an agreement by the individual to serve full-time as a public health professional for a period of time equal to 2 years or such longer period as the individual may agree to; and

''(3) in the case of an individual described in subsection (b)(1)(C) who is in the final year of study and who has accepted employment as a public health professional, in accordance with section 340L(c), an agreement on the part of the individual to complete the education or training, maintain an acceptable level of academic standing (as determined by the educational institution offering the course of study or training), and serve the period of obligated service described in paragraph (2).

''(d) PAYMENTS.—

''(1) IN GENERAL.—A loan repayment provided for an individual under a written contract under the

Program shall consist of payment, in accordance with paragraph (2), on behalf of the individual of the principal, interest, and related expenses on government and commercial loans received by the individual regarding the undergraduate or graduate education of the individual (or both), which loans were made for reasonable educational expenses, including tuition, fees, books, equipment, and laboratory expenses, incurred by the individual.

''(2) PAYMENTS FOR YEARS SERVED.—

''(A) IN GENERAL.—For each year of obligated service that an individual contracts to serve under subsection (c), the Secretary may pay up to $35,000 (plus, beginning with fiscal year 2012, an amount determined by the Secretary on an annual basis to reflect inflation) on behalf of the individual for loans described in paragraph (1).

''(B) REPAYMENT SCHEDULE.—Any arrangement made by the Secretary for the making of loan repayments in accordance with this subsection shall provide that any repayments for a year of obligated service shall be made no later than the end of the fiscal year in which the individual completes such year of service.

''(e) APPLICATION OF CERTAIN PROVISIONS.—The provisions of subpart III shall, except as inconsistent with this subpart, apply to the loan repayment program under this section in the same manner and to the same extent as such provisions apply to the National Health Service Corps Loan Repayment Program established under section 338B.''.

SEC. 2232. ENHANCING THE PUBLIC HEALTH WORKFORCE.

Section 765 (42 U.S.C. 295) is amended to read as follows:

''SEC. 765. ENHANCING THE PUBLIC HEALTH WORKFORCE.

''(a) PROGRAM.—The Secretary, acting through the Administrator of the Health Resources and Services Administration and in consultation with the Director of the Centers for Disease Control and Prevention, shall establish a public health workforce training and enhancement program consisting of awarding grants and contracts under subsection (b).

''(b) GRANTS AND CONTRACTS.—The Secretary shall award grants to, or enter into contracts with, eligible entities—

''(1) to plan, develop, operate, or participate in, an accredited professional training program in the field of public health (including such a program in nursing; health administration, management, or pol-

icy; preventive medicine; laboratory science; veterinary medicine; or dental medicine) for members of the public health workforce, including midcareer professionals;

''(2) to provide financial assistance in the form of traineeships and fellowships to students who are participants in any such program and who plan to specialize or work in the field of public health;

''(3) to plan, develop, operate, or participate in a program for the training of public health professionals who plan to teach in any program described in paragraph (1); and

''(4) to provide financial assistance in the form of traineeships and fellowships to public health professionals who are participants in any program described in paragraph (1) and who plan to teach in the field of public health, including nursing; health administration, management, or policy; preventive medicine; laboratory science; veterinary medicine; or dental medicine.

''(c) ELIGIBILITY.—To be eligible for a grant or contract under this section, an entity shall be—

''(1) an accredited health professions school, including an accredited school or program of public health; nursing; health administration, management,

or policy; preventive medicine; laboratory science; veterinary medicine; or dental medicine;

''(2) a State, local, or tribal health department;

''(3) a public or private nonprofit entity; or

''(4) a consortium of 2 or more entities described in paragraphs (1) through (3).

''(d) PREFERENCE.—In awarding grants or contracts under this section, the Secretary shall give preference to entities that have a demonstrated record of at least one of the following:

''(1) Training a high or significantly improved percentage of public health professionals who serve in underserved communities.

''(2) Training individuals who are from disadvantaged backgrounds (including racial and ethnic minorities underrepresented among public health professionals).

''(3) Training individuals in public health specialties experiencing a significant shortage of public health professionals (as determined by the Secretary).

''(4) Training a high or significantly improved percentage of public health professionals serving in the Federal Government or a State, local, or tribal government.

''(e) REPORT.—The Secretary shall submit to the Congress an annual report on the program carried out under this section.''.

SEC. 2233. PUBLIC HEALTH TRAINING CENTERS.

Section 766 (42 U.S.C. 295a) is amended—

(1) in subsection (b)(1), by striking ''in furtherance of the goals established by the Secretary for the year 2000'' and inserting ''in furtherance of the goals established by the Secretary in the national prevention and wellness strategy under section 3121''; and

(2) by adding at the end the following:

''(d) REPORT.—The Secretary shall submit to the Congress an annual report on the program carried out under this section.''.

SEC. 2234. PREVENTIVE MEDICINE AND PUBLIC HEALTH TRAINING GRANT PROGRAM.

Section 768 (42 U.S.C. 295c) is amended to read as follows:

''SEC. 768. PREVENTIVE MEDICINE AND PUBLIC HEALTH TRAINING GRANT PROGRAM.

''(a) GRANTS.—The Secretary, acting through the Administrator of the Health Resources and Services Administration and in consultation with the Director of the Centers for Disease Control and Prevention, shall award

grants to, or enter into contracts with, eligible entities to provide training to graduate medical residents in preventive medicine specialties.

''(b) ELIGIBILITY.—To be eligible for a grant or contract under subsection (a), an entity shall be—

''(1) an accredited school of public health or school of medicine or osteopathic medicine;

''(2) an accredited public or private nonprofit hospital;

''(3) a State, local, or tribal health department; or

''(4) a consortium of 2 or more entities described in paragraphs (1) through (3).

''(c) USE OF FUNDS.—Amounts received under a grant or contract under this section shall be used to—

''(1) plan, develop (including the development of curricula), operate, or participate in an accredited residency or internship program in preventive medicine or public health;

''(2) defray the costs of practicum experiences, as required in such a program; and

''(3) establish, maintain, or improve—

''(A) academic administrative units (including departments, divisions, or other appro-

priate units) in preventive medicine and public health; or

''(B) programs that improve clinical teaching in preventive medicine and public health.

''(d) REPORT.—The Secretary shall submit to the Congress an annual report on the program carried out under this section.''.

SEC. 2235. AUTHORIZATION OF APPROPRIATIONS.

(a) IN GENERAL.—Section 799C, as added by section 2216 of this Act, is amended by adding at the end the following:

''(b) PUBLIC HEALTH WORKFORCE.—For the purpose of carrying out subpart XII of part D of title III and sections 765, 766, and 768, in addition to any other amounts authorized to be appropriated for such purpose, there are authorized to be appropriated, out of any monies in the Public Health Investment Fund, the following:

''(1) $51,000,000 for fiscal year 2011.

''(2) $54,000,000 for fiscal year 2012.

''(3) $57,000,000 for fiscal year 2013.

''(4) $59,000,000 for fiscal year 2014.

''(5) $62,000,000 for fiscal year 2015.''.

(b) EXISTING AUTHORIZATION OF APPROPRIATIONS.—Subsection (a) of section 770 (42 U.S.C. 295e) is amended by striking ''2002'' and inserting ''2015''.

Subtitle D—Adapting Workforce to Evolving Health System Needs

PART 1—HEALTH PROFESSIONS TRAINING FOR DIVERSITY

SEC. 2241. SCHOLARSHIPS FOR DISADVANTAGED STUDENTS, LOAN REPAYMENTS AND FELLOWSHIPS REGARDING FACULTY POSITIONS, AND EDUCATIONAL ASSISTANCE IN THE HEALTH PROFESSIONS REGARDING INDIVIDUALS FROM DISADVANTAGED BACKGROUNDS.

Paragraph (1) of section 738(a) (42 U.S.C. 293b(a)) is amended by striking ''not more than $20,000'' and all that follows through the end of the paragraph and inserting: ''not more than $35,000 (plus, beginning with fiscal year 2012, an amount determined by the Secretary on an annual basis to reflect inflation) of the principal and interest of the educational loans of such individuals.''.

SEC. 2242. NURSING WORKFORCE DIVERSITY GRANTS.

Subsection (b) of section 821 (42 U.S.C. 296m) is amended—

(1) in the heading, by striking ''GUIDANCE'' and inserting ''CONSULTATION''; and

(2) by striking ''shall take into consideration'' and all that follows through ''consult with nursing

associations'' and inserting ''shall, as appropriate, consult with nursing associations''.

SEC. 2243. COORDINATION OF DIVERSITY AND CULTURAL COMPETENCY PROGRAMS.

(a) IN GENERAL.—Title VII (42 U.S.C. 292 et seq.) is amended by inserting after section 739 the following:

''SEC. 739A. COORDINATION OF DIVERSITY AND CULTURAL COMPETENCY PROGRAMS.

''The Secretary shall, to the extent practicable, coordinate the activities carried out under this part and section 821 in order to enhance the effectiveness of such activities and avoid duplication of effort.''.

(b) REPORT.—Section 736 (42 U.S.C. 293) is amended—

(1) by redesignating subsection (h) as subsection (i); and

(2) by inserting after subsection (g) the following:

''(h) REPORT.—The Secretary shall submit to the Congress an annual report on the activities carried out under this section.''.

PART 2—INTERDISCIPLINARY TRAINING PROGRAMS

SEC. 2251. CULTURAL AND LINGUISTIC COMPETENCY TRAINING FOR HEALTH PROFESSIONALS.

Section 741 (42 U.S.C. 293e) is amended—

(1) in the section heading, by striking ''**GRANTS FOR HEALTH PROFESSIONS EDUCATION**'' and inserting ''**CULTURAL AND LINGUISTIC COMPETENCY TRAINING FOR HEALTH PROFESSIONALS**'';

(2) by redesignating subsection (b) as subsection (h); and

(3) by striking subsection (a) and inserting the following:

''(a) PROGRAM.—The Secretary shall establish a cultural and linguistic competency training program for health professionals, including nurse professionals, consisting of awarding grants and contracts under subsection (b).

''(b) CULTURAL AND LINGUISTIC COMPETENCY TRAINING.—The Secretary shall award grants to, or enter into contracts with, eligible entities—

''(1) to test, develop, and evaluate models of cultural and linguistic competency training (including continuing education) for health professionals; and

''(2) to implement cultural and linguistic competency training programs for health professionals developed under paragraph (1) or otherwise.

''(c) ELIGIBILITY.—To be eligible for a grant or contract under subsection (b), an entity shall be—

''(1) an accredited health professions school or program;

''(2) an academic health center;

''(3) a public or private nonprofit entity; or

''(4) a consortium of 2 or more entities described in paragraphs (1) through (3).

''(d) PREFERENCE.—In awarding grants and contracts under this section, the Secretary shall give preference to entities that have a demonstrated record of at least one of the following:

''(1) Addressing, or partnering with an entity with experience addressing, the cultural and linguistic competency needs of the population to be served through the grant or contract.

''(2) Addressing health disparities.

''(3) Placing health professionals in regions experiencing significant changes in the cultural and linguistic demographics of populations, including communities along the United States-Mexico border.

''(4) Carrying out activities described in subsection (b) with respect to more than one health profession discipline, specialty, or subspecialty.

''(e) CONSULTATION.—The Secretary shall carry out this section in consultation with the heads of appropriate health agencies and offices in the Department of Health and Human Services, including the Office of Minority Health and the National Center on Minority Health and Health Disparities.

''(f) DEFINITION.—In this section, the term 'health disparities' has the meaning given to the term in section 3171.

''(g) REPORT.—The Secretary shall submit to the Congress an annual report on the program carried out under this section.''.

SEC. 2252. INNOVATIONS IN INTERDISCIPLINARY CARE TRAINING.

Part D of title VII (42 U.S.C. 294 et seq.) is amended by adding at the end the following:

''SEC. 759. INNOVATIONS IN INTERDISCIPLINARY CARE TRAINING.

''(a) PROGRAM.—The Secretary shall establish an innovations in interdisciplinary care training program consisting of awarding grants and contracts under subsection (b).

''(b) TRAINING PROGRAMS.—The Secretary shall award grants to, or enter into contracts with, eligible entities—

''(1) to test, develop, and evaluate health professional training programs (including continuing education) designed to promote—

''(A) the delivery of health services through interdisciplinary and team-based models, which may include patient-centered medical home models, medication therapy management models, and models integrating physical, mental, or oral health services; and

''(B) coordination of the delivery of health care within and across settings, including health care institutions, community-based settings, and the patient's home; and

''(2) to implement such training programs developed under paragraph (1) or otherwise.

''(c) ELIGIBILITY.—To be eligible for a grant or contract under subsection (b), an entity shall be—

''(1) an accredited health professions school or program;

''(2) an academic health center;

''(3) a public or private nonprofit entity (including an area health education center or a geriatric education center); or

''(4) a consortium of 2 or more entities described in paragraphs (1) through (3).

''(d) PREFERENCES.—In awarding grants and contracts under this section, the Secretary shall give preference to entities that have a demonstrated record of at least one of the following:

''(1) Training a high or significantly improved percentage of health professionals who serve in underserved communities.

''(2) Broad interdisciplinary team-based collaborations.

''(3) Addressing health disparities.

''(e) REPORT.—The Secretary shall submit to the Congress an annual report on the program carried out under this section.

''(f) DEFINITIONS.—In this section:

''(1) The term 'health disparities' has the meaning given the term in section 3171.

''(2) The term 'interdisciplinary' means collaboration across health professions and specialties, which may include public health, nursing, allied

health, dietetics or nutrition, and appropriate health specialties.''.

PART 3—ADVISORY COMMITTEE ON HEALTH WORKFORCE EVALUATION AND ASSESSMENT

SEC. 2261. HEALTH WORKFORCE EVALUATION AND ASSESSMENT.

Subpart 1 of part E of title VII (42 U.S.C. 294n et seq.) is amended by adding at the end the following:

''SEC. 764. HEALTH WORKFORCE EVALUATION AND ASSESSMENT.

''(a) ADVISORY COMMITTEE.—The Secretary, acting through the Assistant Secretary for Health, shall establish a permanent advisory committee to be known as the Advisory Committee on Health Workforce Evaluation and Assessment (referred to in this section as the 'Advisory Committee') to develop and implement an integrated, coordinated, and strategic national health workforce policy reflective of current and evolving health workforce needs.

''(b) RESPONSIBILITIES.—The Advisory Committee shall—

''(1) not later than 1 year after the date of the establishment of the Advisory Committee, submit recommendations to the Secretary on—

''(A) classifications of the health workforce to ensure consistency of data collection on the health workforce; and

''(B) based on such classifications, standardized methodologies and procedures to enumerate the health workforce;

''(2) not later than 2 years after the date of the establishment of the Advisory Committee, submit recommendations to the Secretary on—

''(A) the supply, diversity, and geographic distribution of the health workforce;

''(B) the retention and expansion of the health workforce (on a short- and long-term basis) to ensure quality and adequacy of such workforce; and

''(C) policies to carry out the recommendations made pursuant to subparagraphs (A) and (B); and

''(3) not later than 4 years after the date of the establishment of the Advisory Committee, and every 2 years thereafter, submit updated recommendations to the Secretary under paragraphs (1) and (2).

''(c) ROLE OF AGENCY.—The Secretary shall provide ongoing administrative, research, and technical support for the operations of the Advisory Committee, including

coordinating and supporting the dissemination of the recommendations of the Advisory Committee.

''(d) MEMBERSHIP.—

''(1) NUMBER; APPOINTMENT.—The Secretary shall appoint 15 members to serve on the Advisory Committee.

''(2) TERMS.—

''(A) IN GENERAL.—The Secretary shall appoint members of the Advisory Committee for a term of 3 years and may reappoint such members, but the Secretary may not appoint any member to serve more than a total of 6 years.

''(B) STAGGERED TERMS.—Notwithstanding subparagraph (A), of the members first appointed to the Advisory Committee under paragraph (1)—

''(i) 5 shall be appointed for a term of 1 year;

''(ii) 5 shall be appointed for a term of 2 years; and

''(iii) 5 shall be appointed for a term of 3 years.

''(3) QUALIFICATIONS.—Members of the Advisory Committee shall be appointed from among indi-

viduals who possess expertise in at least one of the following areas:

''(A) Conducting and interpreting health workforce market analysis, including health care labor workforce analysis.

''(B) Conducting and interpreting health finance and economics research.

''(C) Delivering and administering health care services.

''(D) Delivering and administering health workforce education and training.

''(4) REPRESENTATION.—In appointing members of the Advisory Committee, the Secretary shall—

''(A) include no less than one representative of each of—

''(i) health professionals within the health workforce;

''(ii) health care patients and consumers;

''(iii) employers;

''(iv) labor unions; and

''(v) third-party health payors; and

''(B) ensure that—

''(i) all areas of expertise described in paragraph (3) are represented;

''(ii) the members of the Advisory Committee include members who, collectively, have significant experience working with—

''(I) populations in urban and federally designated rural and non-metropolitan areas; and

''(II) populations who are underrepresented in the health professions, including underrepresented minority groups; and

''(iii) individuals who are directly involved in health professions education or practice do not constitute a majority of the members of the Advisory Committee.

''(5) DISCLOSURE AND CONFLICTS OF INTEREST.—Members of the Advisory Committee shall not be considered employees of the Federal Government by reason of service on the Advisory Committee, except members of the Advisory Committee shall be considered to be special Government employees within the meaning of section 107 of the Ethics in Government Act of 1978 (5 U.S.C. App.) and section

208 of title 18, United States Code, for the purposes of disclosure and management of conflicts of interest under those sections.

''(6) NO PAY; RECEIPT OF TRAVEL EXPENSES.—Members of the Advisory Committee shall not receive any pay for service on the Committee, but may receive travel expenses, including a per diem, in accordance with applicable provisions of subchapter I of chapter 57 of title 5, United States Code.

''(e) CONSULTATION.—In carrying out this section, the Secretary shall consult with the Secretary of Education and the Secretary of Labor.

''(f) COLLABORATION.—The Advisory Committee shall collaborate with the advisory bodies at the Health Resources and Services Administration, the National Advisory Council (as authorized in section 337), the Advisory Committee on Training in Primary Care Medicine and Dentistry (as authorized in section 749A), the Advisory Committee on Interdisciplinary, Community-Based Linkages (as authorized in section 756), the Advisory Council on Graduate Medical Education (as authorized in section 762), and the National Advisory Council on Nurse Education and Practice (as authorized in section 851).

''(g) FACA.—The Federal Advisory Committee Act (5 U.S.C. App.) except for section 14 of such Act shall apply to the Advisory Committee under this section only to the extent that the provisions of such Act do not conflict with the requirements of this section.

''(h) REPORT.—The Secretary shall submit to the Congress an annual report on the activities of the Advisory Committee.

''(i) DEFINITION.—In this section, the term 'health workforce' includes all health care providers with direct patient care and support responsibilities, including physicians, nurses, physician assistants, pharmacists, oral health professionals (as defined in section 749(f)(2)), allied health professionals, mental and behavioral health professionals (as defined in section 775(f)(2)), and public health professionals (including veterinarians engaged in public health practice).''.

PART 4—HEALTH WORKFORCE ASSESSMENT

SEC. 2271. HEALTH WORKFORCE ASSESSMENT.

(a) IN GENERAL.—Section 761 (42 U.S.C. 294n) is amended—

(1) by redesignating subsection (c) as subsection (e); and

(2) by striking subsections (a) and (b) and inserting the following:

''(a) IN GENERAL.—The Secretary shall, based upon the classifications and standardized methodologies and procedures developed by the Advisory Committee on Health Workforce Evaluation and Assessment under section 764(b)—

''(1) collect data on the health workforce (as defined in section 764(i)), disaggregated by field, discipline, and specialty, with respect to—

''(A) the supply (including retention) of health professionals relative to the demand for such professionals;

''(B) the diversity of health professionals (including with respect to race, ethnic background, and sex); and

''(C) the geographic distribution of health professionals; and

''(2) collect such data on individuals participating in the programs authorized by subtitles A, B, and C and part 1 of subtitle D of title II of division C of the Affordable Health Care for America Act.

''(b) GRANTS AND CONTRACTS FOR HEALTH WORKFORCE ANALYSIS.—

''(1) IN GENERAL.—The Secretary may award grants to, or enter into contracts with, eligible entities to carry out subsection (a).

''(2) ELIGIBILITY.—To be eligible for a grant or contract under this subsection, an entity shall be—

''(A) an accredited health professions school or program;

''(B) an academic health center;

''(C) a State, local, or tribal government;

''(D) a public or private entity; or

''(E) a consortium of 2 or more entities described in subparagraphs (A) through (D).

''(c) COLLABORATION AND DATA SHARING.—The Secretary shall collaborate with Federal departments and agencies, health professions organizations (including health professions education organizations), and professional medical societies for the purpose of carrying out subsection (a).

''(d) REPORT.—The Secretary shall submit to the Congress an annual report on the data collected under subsection (a).''.

(b) PERIOD BEFORE COMPLETION OF NATIONAL STRATEGY.—Pending completion of the classifications and standardized methodologies and procedures developed by the Advisory Committee on Health Workforce Evaluation and Assessment under section 764(b) of the Public Health Service Act, as added by section 2261, the Secretary of

Health and Human Services, acting through the Administrator of the Health Resources and Services Administration and in consultation with such Advisory Committee, may make a judgment about the classifications, methodologies, and procedures to be used for collection of data under section 761(a) of the Public Health Service Act, as amended by this section.

PART 5—AUTHORIZATION OF APPROPRIATIONS

SEC. 2281. AUTHORIZATION OF APPROPRIATIONS.

(a) IN GENERAL.—Section 799C, as added and amended, is further amended by adding at the end the following:

''(c) HEALTH PROFESSIONS TRAINING FOR DIVERSITY.—For the purpose of carrying out sections 736, 737, 738, 739, and 739A, in addition to any other amounts authorized to be appropriated for such purpose, there are authorized to be appropriated, out of any monies in the Public Health Investment Fund, the following:

''(1) $90,000,000 for fiscal year 2011.

''(2) $97,000,000 for fiscal year 2012.

''(3) $100,000,000 for fiscal year 2013.

''(4) $104,000,000 for fiscal year 2014.

''(5) $110,000,000 for fiscal year 2015.

''(d) INTERDISCIPLINARY TRAINING PROGRAMS, ADVISORY COMMITTEE ON HEALTH WORKFORCE EVALUA-

tion and Assessment, and Health Workforce Assessment.—For the purpose of carrying out sections 741, 759, 761, and 764, in addition to any other amounts authorized to be appropriated for such purpose, there are authorized to be appropriated, out of any monies in the Public Health Investment Fund, the following:

''(1) $87,000,000 for fiscal year 2011.

''(2) $97,000,000 for fiscal year 2012.

''(3) $103,000,000 for fiscal year 2013.

''(4) $105,000,000 for fiscal year 2014.

''(5) $113,000,000 for fiscal year 2015.''.

(b) Existing Authorizations of Appropriations.—

(1) Section 736.—Paragraph (1) of section 736(i) (42 U.S.C. 293(h)), as redesignated, is amended by striking ''2002'' and inserting ''2015''.

(2) Sections 737, 738, and 739.—Subsections (a), (b), and (c) of section 740 are amended by striking ''2002'' each place it appears and inserting ''2015''.

(3) Section 741.—Subsection (h), as so redesignated, of section 741 is amended—

(A) by striking ''and'' after ''fiscal year 2003,''; and

(B) by inserting ", and such sums as may be necessary for each subsequent fiscal year through the end of fiscal year 2015" before the period at the end.

(4) SECTION 761.—Subsection (e)(1), as so redesignated, of section 761 is amended by striking "2002" and inserting "2015".

TITLE III—PREVENTION AND WELLNESS

SEC. 2301. PREVENTION AND WELLNESS.

(a) IN GENERAL.—The Public Health Service Act (42 U.S.C. 201 et seq.) is amended by inserting after title XXX the following:

"TITLE XXXI—PREVENTION AND WELLNESS

"Subtitle A—Prevention and Wellness Trust

"SEC. 3111. PREVENTION AND WELLNESS TRUST.

"(a) DEPOSITS INTO TRUST.—There is established a Prevention and Wellness Trust. There are authorized to be appropriated to the Trust—

"(1) out of the general fund of the Treasury, amounts described in section 2002(b)(2)(A)(ii) of the Affordable Health Care for America Act for each fiscal year; and

''(2) in addition, out of any monies in the Public Health Investment Fund—

''(A) for fiscal year 2011, $2,400,000,000;

''(B) for fiscal year 2012, $2,845,000,000;

''(C) for fiscal year 2013, $3,100,000,000;

''(D) for fiscal year 2014, $3,455,000,000; and

''(E) for fiscal year 2015, $3,600,000,000.

''(b) AVAILABILITY OF FUNDS.—Amounts in the Prevention and Wellness Trust shall be available, as provided in advance in appropriation Acts, for carrying out this title.

''(c) ALLOCATION.—Of the amounts authorized to be appropriated in subsection (a)(2), there are authorized to be appropriated—

''(1) for carrying out subtitle C (Prevention Task Forces), $30,000,000 for each of fiscal years 2011 through 2015;

''(2) for carrying out subtitle D (Prevention and Wellness Research)—

''(A) for fiscal year 2011, $155,000,000;

''(B) for fiscal year 2012, $205,000,000;

''(C) for fiscal year 2013, $255,000,000;

''(D) for fiscal year 2014, $305,000,000; and

''(E) for fiscal year 2015, $355,000,000;

''(3) for carrying out subtitle E (Delivery of Community Preventive and Wellness Services)—

''(A) for fiscal year 2011, $1,065,000,000;

''(B) for fiscal year 2012, $1,260,000,000;

''(C) for fiscal year 2013, $1,365,000,000;

''(D) for fiscal year 2014, $1,570,000,000; and

''(E) for fiscal year 2015, $1,600,000,000;

''(4) for carrying out section 3161 (Core Public Health Infrastructure for State, Local, and Tribal Health Departments)—

''(A) for fiscal year 2011, $800,000,000;

''(B) for fiscal year 2012, $1,000,000,000;

''(C) for fiscal year 2013, $1,100,000,000;

''(D) for fiscal year 2014, $1,200,000,000; and

''(E) for fiscal year 2015, $1,265,000,000; and

''(5) for carrying out section 3162 (Core Public Health Infrastructure and Activities for CDC), $350,000,000 for each of fiscal years 2011 through 2015.

"Subtitle B—National Prevention and Wellness Strategy

"SEC. 3121. NATIONAL PREVENTION AND WELLNESS STRATEGY.

''(a) IN GENERAL.—The Secretary shall submit to the Congress within one year after the date of the enactment of this section, and at least every 2 years thereafter, a national strategy that is designed to improve the Nation's health through evidence-based clinical and community prevention and wellness activities (in this section referred to as 'prevention and wellness activities'), including core public health infrastructure improvement activities.

''(b) CONTENTS.—The strategy under subsection (a) shall include each of the following:

''(1) Identification of specific national goals and objectives in prevention and wellness activities that take into account appropriate public health measures and standards, including departmental measures and standards (including Healthy People and National Public Health Performance Standards).

''(2) Establishment of national priorities for prevention and wellness, taking into account unmet prevention and wellness needs.

''(3) Establishment of national priorities for research on prevention and wellness, taking into ac-

count unanswered research questions on prevention and wellness.

''(4) Identification of health disparities in prevention and wellness.

''(5) Review of prevention payment incentives, the prevention workforce, and prevention delivery system capacity.

''(6) A plan for addressing and implementing paragraphs (1) through (5).

''(c) CONSULTATION.—In developing or revising the strategy under subsection (a), the Secretary shall consult with the following:

''(1) The heads of appropriate health agencies and offices in the Department, including the Office of the Surgeon General of the Public Health Service, the Office of Minority Health, the Office on Women's Health, and the Substance Abuse and Mental Health Services Administration.

''(2) As appropriate, the heads of other Federal departments and agencies whose programs have a significant impact upon health (as determined by the Secretary).

''(3) As appropriate, nonprofit and for-profit entities.

''(4) The Association of State and Territorial Health Officials and the National Association of County and City Health Officials.

''(5) The Task Force on Community Preventive Services and the Task Force on Clinical Preventive Services.

''Subtitle C—Prevention Task Forces

''SEC. 3131. TASK FORCE ON CLINICAL PREVENTIVE SERVICES.

''(a) IN GENERAL.—The Secretary, acting through the Director of the Agency for Healthcare Research and Quality, shall establish a permanent task force to be known as the Task Force on Clinical Preventive Services (in this section referred to as the 'Task Force').

''(b) RESPONSIBILITIES.—The Task Force shall—

''(1) identify clinical preventive services for review;

''(2) review the scientific evidence related to the benefits, effectiveness, appropriateness, and costs of clinical preventive services identified under paragraph (1) for the purpose of developing, updating, publishing, and disseminating evidence-based recommendations on the use of such services;

''(3) as appropriate, take into account health disparities in developing, updating, publishing, and disseminating evidence-based recommendations on the use of such services;

''(4) identify gaps in clinical preventive services research and evaluation and recommend priority areas for such research and evaluation;

''(5) pursuant to section 3143(c), determine whether subsidies and rewards meet the Task Force's standards for a grade of A or B;

''(6) as appropriate, consult with the clinical prevention stakeholders board in accordance with subsection (f);

''(7) consult with the Task Force on Community Preventive Services established under section 3132; and

''(8) as appropriate, in carrying out this section, consider the national strategy under section 3121.

''(c) ROLE OF AGENCY.—The Secretary shall provide ongoing administrative, research, and technical support for the operations of the Task Force, including coordinating and supporting the dissemination of the recommendations of the Task Force.

''(d) MEMBERSHIP.—

''(1) NUMBER; APPOINTMENT.—The Task Force shall be composed of 30 members, appointed by the Secretary.

''(2) TERMS.—

''(A) IN GENERAL.—The Secretary shall appoint members of the Task Force for a term of 6 years and may reappoint such members, but the Secretary may not appoint any member to serve more than a total of 12 years.

''(B) STAGGERED TERMS.—Notwithstanding subparagraph (A), of the members first appointed to serve on the Task Force after the enactment of this title—

''(i) 10 shall be appointed for a term of 2 years;

''(ii) 10 shall be appointed for a term of 4 years; and

''(iii) 10 shall be appointed for a term of 6 years.

''(3) QUALIFICATIONS.—Members of the Task Force shall be appointed from among individuals who possess expertise in at least one of the following areas:

''(A) Health promotion and disease prevention.

''(B) Evaluation of research and systematic evidence reviews.

''(C) Application of systematic evidence reviews to clinical decisionmaking or health policy.

''(D) Clinical primary care in child and adolescent health.

''(E) Clinical primary care in adult health, including women's health.

''(F) Clinical primary care in geriatrics.

''(G) Clinical counseling and behavioral services for primary care patients.

''(4) REPRESENTATION.—In appointing members of the Task Force, the Secretary shall ensure that—

''(A) all areas of expertise described in paragraph (3) are represented; and

''(B) the members of the Task Force include individuals with expertise in health disparities.

''(e) SUBGROUPS.—As appropriate to maximize efficiency, the Task Force may delegate authority for conducting reviews and making recommendations to subgroups consisting of Task Force members, subject to final approval by the Task Force.

''(f) CLINICAL PREVENTION STAKEHOLDERS BOARD.—

''(1) IN GENERAL.—The Task Force shall convene a clinical prevention stakeholders board composed of representatives of appropriate public and private entities with an interest in clinical preventive services to advise the Task Force on developing, updating, publishing, and disseminating evidence-based recommendations on the use of clinical preventive services.

''(2) MEMBERSHIP.—The members of the clinical prevention stakeholders board shall include representatives of the following:

''(A) Health care consumers and patient groups.

''(B) Providers of clinical preventive services, including community-based providers.

''(C) Federal departments and agencies, including—

''(i) appropriate health agencies and offices in the Department, including the Office of the Surgeon General of the Public Health Service, the Office of Minority Health, the National Center on Minority

Health and Health Disparities, and the Office on Women's Health; and

''(ii) as appropriate, other Federal departments and agencies whose programs have a significant impact upon health (as determined by the Secretary).

''(D) Private health care payors.

''(3) RESPONSIBILITIES.—In accordance with subsection (b)(6), the clinical prevention stakeholders board shall—

''(A) recommend clinical preventive services for review by the Task Force;

''(B) suggest scientific evidence for consideration by the Task Force related to reviews undertaken by the Task Force;

''(C) provide feedback regarding draft recommendations by the Task Force; and

''(D) assist with efforts regarding dissemination of recommendations by the Director of the Agency for Healthcare Research and Quality.

''(g) DISCLOSURE AND CONFLICTS OF INTEREST.—Members of the Task Force or the clinical prevention stakeholders board shall not be considered employees of the Federal Government by reason of service on the Task

Force or the clinical prevention stakeholders board, except members of the Task Force or the clinical prevention stakeholders board shall be considered to be special Government employees within the meaning of section 107 of the Ethics in Government Act of 1978 (5 U.S.C. App.) and section 208 of title 18, United States Code, for the purposes of disclosure and management of conflicts of interest under those sections.

''(h) NO PAY; RECEIPT OF TRAVEL EXPENSES.—Members of the Task Force or the clinical prevention stakeholders board shall not receive any pay for service on the Task Force, but may receive travel expenses, including a per diem, in accordance with applicable provisions of subchapter I of chapter 57 of title 5, United States Code.

''(i) APPLICATION OF FACA.—The Federal Advisory Committee Act (5 U.S.C. App.) except for section 14 of such Act shall apply to the Task Force to the extent that the provisions of such Act do not conflict with the provisions of this title.

''(j) REPORT.—The Secretary shall submit to the Congress an annual report on the Task Force, including with respect to gaps identified and recommendations made under subsection (b)(4).

"SEC. 3132. TASK FORCE ON COMMUNITY PREVENTIVE SERVICES.

''(a) IN GENERAL.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall establish a permanent task force to be known as the Task Force on Community Preventive Services (in this section referred to as the 'Task Force').

''(b) RESPONSIBILITIES.—The Task Force shall—

''(1) identify community preventive services for review;

''(2) review the scientific evidence related to the benefits, effectiveness, appropriateness, and costs of community preventive services identified under paragraph (1) for the purpose of developing, updating, publishing, and disseminating evidence-based recommendations on the use of such services;

''(3) as appropriate, take into account health disparities in developing, updating, publishing, and disseminating evidence-based recommendations on the use of such services;

''(4) identify gaps in community preventive services research and evaluation and recommend priority areas for such research and evaluation;

''(5) pursuant to section 3143(d), determine whether subsidies and rewards are effective;

''(6) as appropriate, consult with the community prevention stakeholders board in accordance with subsection (f);

''(7) consult with the Task Force on Clinical Preventive Services established under section 3131; and

''(8) as appropriate, in carrying out this section, consider the national strategy under section 3121.

''(c) ROLE OF AGENCY.—The Secretary shall provide ongoing administrative, research, and technical support for the operations of the Task Force, including coordinating and supporting the dissemination of the recommendations of the Task Force.

''(d) MEMBERSHIP.—

''(1) NUMBER; APPOINTMENT.—The Task Force shall be composed of 30 members, appointed by the Secretary.

''(2) TERMS.—

''(A) IN GENERAL.—The Secretary shall appoint members of the Task Force for a term of 6 years and may reappoint such members, but the Secretary may not appoint any member to serve more than a total of 12 years.

''(B) STAGGERED TERMS.—Notwithstanding subparagraph (A), of the members first appointed to serve on the Task Force after the enactment of this section—

''(i) 10 shall be appointed for a term of 2 years;

''(ii) 10 shall be appointed for a term of 4 years; and

''(iii) 10 shall be appointed for a term of 6 years.

''(3) QUALIFICATIONS.—Members of the Task Force shall be appointed from among individuals who possess expertise in at least one of the following areas:

''(A) Public health.

''(B) Evaluation of research and systematic evidence reviews.

''(C) Disciplines relevant to community preventive services, including health promotion; disease prevention; chronic disease; worksite health; school-site health; qualitative and quantitative analysis; and health economics, policy, law, and statistics.

''(4) REPRESENTATION.—In appointing members of the Task Force, the Secretary—

''(A) shall ensure that all areas of expertise described in paragraph (3) are represented;

''(B) shall ensure that such members include sufficient representatives of each of—

''(i) State health officers;

''(ii) local health officers;

''(iii) health care practitioners; and

''(iv) public health practitioners; and

''(C) shall appoint individuals who have expertise in health disparities.

''(e) SUBGROUPS.—As appropriate to maximize efficiency, the Task Force may delegate authority for conducting reviews and making recommendations to subgroups consisting of Task Force members, subject to final approval by the Task Force.

''(f) COMMUNITY PREVENTION STAKEHOLDERS BOARD.—

''(1) IN GENERAL.—The Task Force shall convene a community prevention stakeholders board composed of representatives of appropriate public and private entities with an interest in community preventive services to advise the Task Force on developing, updating, publishing, and disseminating evidence-based recommendations on the use of community preventive services.

''(2) MEMBERSHIP.—The members of the community prevention stakeholders board shall include representatives of the following:

''(A) Health care consumers and patient groups.

''(B) Providers of community preventive services, including community-based providers.

''(C) Federal departments and agencies, including—

''(i) appropriate health agencies and offices in the Department, including the Office of the Surgeon General of the Public Health Service, the Office of Minority Health, the National Center on Minority Health and Health Disparities, and the Office on Women's Health; and

''(ii) as appropriate, other Federal departments and agencies whose programs have a significant impact upon health (as determined by the Secretary).

''(D) Private health care payors.

''(3) RESPONSIBILITIES.—In accordance with subsection (b)(6), the community prevention stakeholders board shall—

''(A) recommend community preventive services for review by the Task Force;

''(B) suggest scientific evidence for consideration by the Task Force related to reviews undertaken by the Task Force;

''(C) provide feedback regarding draft recommendations by the Task Force; and

''(D) assist with efforts regarding dissemination of recommendations by the Director of the Centers for Disease Control and Prevention.

''(g) DISCLOSURE AND CONFLICTS OF INTEREST.—Members of the Task Force or the community prevention stakeholders board shall not be considered employees of the Federal Government by reason of service on the Task Force or the community prevention stakeholders board, except members of the Task Force or the community prevention stakeholders board shall be considered to be special Government employees within the meaning of section 107 of the Ethics in Government Act of 1978 (5 U.S.C. App.) and section 208 of title 18, United States Code, for the purposes of disclosure and management of conflicts of interest under those sections.

''(h) NO PAY; RECEIPT OF TRAVEL EXPENSES.—Members of the Task Force or the community prevention stakeholders board shall not receive any pay for service

on the Task Force, but may receive travel expenses, including a per diem, in accordance with applicable provisions of subchapter I of chapter 57 of title 5, United States Code.

''(i) APPLICATION OF FACA.—The Federal Advisory Committee Act (5 U.S.C. App.) except for section 14 of such Act shall apply to the Task Force to the extent that the provisions of such Act do not conflict with the provisions of this title.

''(j) REPORT.—The Secretary shall submit to the Congress an annual report on the Task Force, including with respect to gaps identified and recommendations made under subsection (b)(4).

''Subtitle D—Prevention and Wellness Research

''SEC. 3141. PREVENTION AND WELLNESS RESEARCH ACTIVITY COORDINATION.

''In conducting or supporting research on prevention and wellness, the Director of the Centers for Disease Control and Prevention, the Director of the National Institutes of Health, and the heads of other agencies within the Department of Health and Human Services conducting or supporting such research, shall take into consideration the national strategy under section 3121 and the recommendations of the Task Force on Clinical Pre-

ventive Services under section 3131 and the Task Force on Community Preventive Services under section 3132.

"SEC. 3142. COMMUNITY PREVENTION AND WELLNESS RESEARCH GRANTS.

"(a) IN GENERAL.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall conduct, or award grants to eligible entities to conduct, research in priority areas identified by the Secretary in the national strategy under section 3121 or by the Task Force on Community Preventive Services as required by section 3132.

"(b) ELIGIBILITY.—To be eligible for a grant under this section, an entity shall be—

"(1) a State, local, or tribal department of health;

"(2) a public or private nonprofit entity; or

"(3) a consortium of 2 or more entities described in paragraphs (1) and (2).

"(c) REPORT.—The Secretary shall submit to the Congress an annual report on the program of research under this section.

"SEC. 3143. RESEARCH ON SUBSIDIES AND REWARDS TO ENCOURAGE WELLNESS AND HEALTHY BEHAVIORS.

"(a) RESEARCH AND DEMONSTRATION PROJECTS.—

''(1) IN GENERAL.—The Secretary shall conduct, or award grants to public or nonprofit private entities to conduct, research and demonstration projects on the use of financial and in-kind subsidies and rewards to encourage individuals and communities to promote wellness, adopt healthy behaviors, and use evidence-based preventive health services.

''(2) FOCUS.—Research and demonstration projects under paragraph (1) shall focus on—

''(A) tobacco use, obesity, and other prevention and wellness priorities identified by the Secretary in the national strategy under section 3121;

''(B) the initiation, maintenance, and long-term sustainability of wellness promotion; adoption of healthy behaviors; and use of evidence-based preventive health services; and

''(C) populations at high risk of preventable diseases and conditions.

''(b) FINDINGS; REPORT.—

''(1) SUBMISSION OF FINDINGS.—The Secretary shall submit the findings of research and demonstration projects under subsection (a) to—

''(A) the Task Force on Clinical Preventive Services established under section 3131 or the

Task Force on Community Preventive Services established under section 3132, as appropriate; and

''(B) the Health Benefits Advisory Committee established by section 223 of the Affordable Health Care for America Act.

''(2) REPORT TO CONGRESS.—Not later than 18 months after the initiation of research and demonstration projects under subsection (a), the Secretary shall submit a report to the Congress on the progress of such research and projects, including any preliminary findings.

''(c) INCLUSION IN ESSENTIAL BENEFITS PACKAGE.—If, on the basis of the findings of research and demonstration projects under subsection (a) or other sources consistent with section 3131, the Task Force on Clinical Preventive Services determines that a subsidy or reward meets the Task Force's standards for a grade A or B, the Secretary shall ensure that the subsidy or reward is included in the essential benefits package under section 222.

''(d) INCLUSION AS ALLOWABLE USE OF COMMUNITY PREVENTION AND WELLNESS SERVICES GRANTS.—If, on the basis of the findings of research and demonstration projects under subsection (a) or other sources consistent

with section 3132, the Task Force on Community Preventive Services determines that a subsidy or reward is effective, the Secretary shall ensure that the subsidy or reward becomes an allowable use of grant funds under section 3151.

''(e) NONDISCRIMINATION; NO TIE TO PREMIUM OR COST SHARING.—In carrying out this section, the Secretary shall ensure that any subsidy or reward—

''(1) does not have a discriminatory effect on the basis of any personal characteristic extraneous to the provision of high-quality health care or related services; and

''(2) is not tied to the premium or cost sharing of an individual under any qualified health benefits plan (as defined in section 100(c)).

"Subtitle E—Delivery of Community Prevention and Wellness Services

"SEC. 3151. COMMUNITY PREVENTION AND WELLNESS SERVICES GRANTS.

''(a) IN GENERAL.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall establish a program for the delivery of community prevention and wellness services consisting of awarding grants to eligible entities—

''(1) to provide evidence-based, community prevention and wellness services in priority areas identified by the Secretary in the national strategy under section 3121; or

''(2) to plan such services.

''(b) ELIGIBILITY.—

''(1) DEFINITION.—To be eligible for a grant under this section, an entity shall be—

''(A) a State, local, or tribal department of health;

''(B) a public or private entity; or

''(C) a consortium that—

''(i) consists of 2 or more entities described in subparagraph (A) or (B); and

''(ii) may be a community partnership representing a Health Empowerment Zone.

''(2) HEALTH EMPOWERMENT ZONE.—In this subsection, the term 'Health Empowerment Zone' means an area—

''(A) in which multiple community prevention and wellness services are implemented in order to address one or more health disparities, including those identified by the Secretary in the national strategy under section 3121; and

''(B) which is represented by a community partnership that demonstrates community support and coordination with State, local, or tribal health departments and includes—

''(i) a broad cross section of stakeholders;

''(ii) residents of the community; and

''(iii) representatives of entities that have a history of working within and serving the community.

''(c) PREFERENCES.—In awarding grants under this section, the Secretary shall give preference to entities that—

''(1) will address one or more goals or objectives identified by the Secretary in the national strategy under section 3121;

''(2) will address significant health disparities, including those identified by the Secretary in the national strategy under section 3121;

''(3) will address unmet community prevention and wellness needs and avoid duplication of effort;

''(4) have been demonstrated to be effective in communities comparable to the proposed target community;

''(5) will contribute to the evidence base for community prevention and wellness services;

''(6) demonstrate that the community prevention and wellness services to be funded will be sustainable; and

''(7) demonstrate coordination or collaboration across governmental and nongovernmental partners.

''(d) HEALTH DISPARITIES.—Of the funds awarded under this section for a fiscal year, the Secretary shall award not less than 50 percent for planning or implementing community prevention and wellness services whose primary purpose is to achieve a measurable reduction in one or more health disparities, including those identified by the Secretary in the national strategy under section 3121.

''(e) EMPHASIS ON RECOMMENDED SERVICES.—For fiscal year 2014 and subsequent fiscal years, the Secretary shall award grants under this section only for planning or implementing services recommended by the Task Force on Community Preventive Services under section 3132 or deemed effective based on a review of comparable rigor (as determined by the Director of the Centers for Disease Control and Prevention).

''(f) PROHIBITED USES OF FUNDS.—An entity that receives a grant under this section may not use funds provided through the grant—

''(1) to build or acquire real property or for construction; or

''(2) for services or planning to the extent that payment has been made, or can reasonably be expected to be made—

''(A) under any insurance policy;

''(B) under any Federal or State health benefits program (including titles XIX and XXI of the Social Security Act); or

''(C) by an entity which provides health services on a prepaid basis.

''(g) REPORT.—The Secretary shall submit to the Congress an annual report on the program of grants awarded under this section.

''(h) DEFINITIONS.—In this section, the term 'evidence-based' means that methodologically sound research has demonstrated a beneficial health effect, in the judgment of the Director of the Centers for Disease Control and Prevention.

"Subtitle F—Core Public Health Infrastructure

"SEC. 3161. CORE PUBLIC HEALTH INFRASTRUCTURE FOR STATE, LOCAL, AND TRIBAL HEALTH DEPARTMENTS.

''(a) PROGRAM.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall establish a core public health infrastructure program consisting of awarding grants under subsection (b).

''(b) GRANTS.—

''(1) AWARD.—For the purpose of addressing core public health infrastructure needs, the Secretary—

''(A) shall award a grant to each State health department; and

''(B) may award grants on a competitive basis to State, local, or tribal health departments.

''(2) ALLOCATION.—Of the total amount of funds awarded as grants under this subsection for a fiscal year—

''(A) not less than 50 percent shall be for grants to State health departments under paragraph (1)(A); and

''(B) not less than 30 percent shall be for grants to State, local, or tribal health departments under paragraph (1)(B).

''(c) USE OF FUNDS.—The Secretary may award a grant to an entity under subsection (b)(1) only if the entity agrees to use the grant to address core public health infrastructure needs, including those identified in the accreditation process under subsection (g).

''(d) FORMULA GRANTS TO STATE HEALTH DEPARTMENTS.—In making grants under subsection (b)(1)(A), the Secretary shall award funds to each State health department in accordance with—

''(1) a formula based on population size; burden of preventable disease and disability; and core public health infrastructure gaps, including those identified in the accreditation process under subsection (g); and

''(2) application requirements established by the Secretary, including a requirement that the State submit a plan that demonstrates to the satisfaction of the Secretary that the State's health department will—

''(A) address its highest priority core public health infrastructure needs; and

''(B) as appropriate, allocate funds to local health departments within the State.

''(e) COMPETITIVE GRANTS TO STATE, LOCAL, AND TRIBAL HEALTH DEPARTMENTS.—In making grants under subsection (b)(1)(B), the Secretary shall give priority to applicants demonstrating core public health infrastructure needs identified in the accreditation process under subsection (g).

''(f) MAINTENANCE OF EFFORT.—The Secretary may award a grant to an entity under subsection (b) only if the entity demonstrates to the satisfaction of the Secretary that—

''(1) funds received through the grant will be expended only to supplement, and not supplant, non-Federal and Federal funds otherwise available to the entity for the purpose of addressing core public health infrastructure needs; and

''(2) with respect to activities for which the grant is awarded, the entity will maintain expenditures of non-Federal amounts for such activities at a level not less than the level of such expenditures maintained by the entity for the fiscal year preceding the fiscal year for which the entity receives the grant.

''(g) ESTABLISHMENT OF A PUBLIC HEALTH ACCREDITATION PROGRAM.—

''(1) IN GENERAL.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall—

''(A) develop, and periodically review and update, standards for voluntary accreditation of State, local, or tribal health departments and public health laboratories for the purpose of advancing the quality and performance of such departments and laboratories; and

''(B) implement a program to accredit such health departments and laboratories in accordance with such standards.

''(2) COOPERATIVE AGREEMENT.—The Secretary may enter into a cooperative agreement with a private nonprofit entity to carry out paragraph (1).

''(h) REPORT.—The Secretary shall submit to the Congress an annual report on progress being made to accredit entities under subsection (g), including—

''(1) a strategy, including goals and objectives, for accrediting entities under subsection (g) and achieving the purpose described in subsection (g)(1); and

''(2) identification of gaps in research related to core public health infrastructure and recommendations of priority areas for such research.

"SEC. 3162. CORE PUBLIC HEALTH INFRASTRUCTURE AND ACTIVITIES FOR CDC.

''(a) IN GENERAL.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall expand and improve the core public health infrastructure and activities of the Centers for Disease Control and Prevention to address unmet and emerging public health needs.

''(b) REPORT.—The Secretary shall submit to the Congress an annual report on the activities funded through this section.

"Subtitle G—General Provisions

"SEC. 3171. DEFINITIONS.

''In this title:

''(1) The term 'core public health infrastructure' includes workforce capacity and competency; laboratory systems; health information, health information systems, and health information analysis; communications; financing; other relevant components of organizational capacity; and other related activities.

''(2) The terms 'Department' and 'departmental' refer to the Department of Health and Human Services.

''(3) The term 'health disparities' includes health and health care disparities and means population-specific differences in the presence of disease, health outcomes, or access to health care. For purposes of the preceding sentence, a population may be delineated by race, ethnicity, primary language, sex, sexual orientation, gender identity, disability, socioeconomic status, or rural, urban, or other geographic setting, and any other population or subpopulation determined by the Secretary to experience significant gaps in disease, health outcomes, or access to health care.

''(4) The term 'tribal' refers to an Indian tribe, a Tribal organization, or an Urban Indian organization, as such terms are defined in section 4 of the Indian Health Care Improvement Act.''.

(b) TRANSITION PROVISIONS APPLICABLE TO TASK FORCES.—

(1) FUNCTIONS, PERSONNEL, ASSETS, LIABILITIES, AND ADMINISTRATIVE ACTIONS.—All functions, personnel, assets, and liabilities of, and administrative actions applicable to, the Preventive

Services Task Force convened under section 915(a) of the Public Health Service Act and the Task Force on Community Preventive Services (as such section and Task Forces were in existence on the day before the date of the enactment of this Act) shall be transferred to the Task Force on Clinical Preventive Services and the Task Force on Community Preventive Services, respectively, established under sections 3131 and 3132 of the Public Health Service Act, as added by subsection (a).

(2) RECOMMENDATIONS.—All recommendations of the Preventive Services Task Force and the Task Force on Community Preventive Services, as in existence on the day before the date of the enactment of this Act, shall be considered to be recommendations of the Task Force on Clinical Preventive Services and the Task Force on Community Preventive Services, respectively, established under sections 3131 and 3132 of the Public Health Service Act, as added by subsection (a).

(3) MEMBERS ALREADY SERVING.—

(A) INITIAL MEMBERS.—The Secretary of Health and Human Services may select those individuals already serving on the Preventive Services Task Force and the Task Force on

Community Preventive Services, as in existence on the day before the date of the enactment of this Act, to be among the first members appointed to the Task Force on Clinical Preventive Services and the Task Force on Community Preventive Services, respectively, under sections 3131 and 3132 of the Public Health Service Act, as added by subsection (a).

(B) CALCULATION OF TOTAL SERVICE.—In calculating the total years of service of a member of a task force for purposes of section 3131(d)(2)(A) or 3132(d)(2)(A) of the Public Health Service Act, as added by subsection (a), the Secretary of Health and Human Services shall not include any period of service by the member on the Preventive Services Task Force or the Task Force on Community Preventive Services, respectively, as in existence on the day before the date of the enactment of this Act.

(c) PERIOD BEFORE COMPLETION OF NATIONAL STRATEGY.—Pending completion of the national strategy under section 3121 of the Public Health Service Act, as added by subsection (a), the Secretary of Health and Human Services, acting through the relevant agency head, may make a judgment about how the strategy will address

an issue and rely on such judgment in carrying out any provision of subtitle C, D, E, or F of title XXXI of such Act, as added by subsection (a), that requires the Secretary—

(1) to take into consideration such strategy;

(2) to conduct or support research or provide services in priority areas identified in such strategy; or

(3) to take any other action in reliance on such strategy.

(d) CONFORMING AMENDMENTS.—

(1) Paragraph (61) of section 3(b) of the Indian Health Care Improvement Act (25 U.S.C. 1602) is amended by striking ''United States Preventive Services Task Force'' and inserting ''Task Force on Clinical Preventive Services''.

(2) Section 126 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (Appendix F of Public Law 106–554) is amended by striking ''United States Preventive Services Task Force'' each place it appears and inserting ''Task Force on Clinical Preventive Services''.

(3) Paragraph (7) of section 317D(a) of the Public Health Service Act (42 U.S.C. 247b–5(a)) is

amended by striking ''United States Preventive Services Task Force'' and inserting ''Task Force on Clinical Preventive Services''.

(4) Section 915 of the Public Health Service Act (42 U.S.C. 299b–4) is amended by striking subsection (a).

(5) Subsections (s)(2)(AA)(iii)(II), (xx)(1), and (ddd)(1)(B) of section 1861 of the Social Security Act (42 U.S.C. 1395x) are amended by striking ''United States Preventive Services Task Force'' each place it appears and inserting ''Task Force on Clinical Preventive Services''.

TITLE IV—QUALITY AND SURVEILLANCE

SEC. 2401. IMPLEMENTATION OF BEST PRACTICES IN THE DELIVERY OF HEALTH CARE.

(a) IN GENERAL.—Title IX of the Public Health Service Act (42 U.S.C. 299 et seq.) is amended—

(1) by redesignating part D as part E;

(2) by redesignating sections 931 through 938 as sections 941 through 948, respectively;

(3) in section 948(1), as redesignated, by striking ''931'' and inserting ''941''; and

(4) by inserting after part C the following:

"PART D—IMPLEMENTATION OF BEST PRACTICES IN THE DELIVERY OF HEALTH CARE

"SEC. 931. CENTER FOR QUALITY IMPROVEMENT.

''(a) IN GENERAL.—There is established the Center for Quality Improvement (referred to in this part as the 'Center'), to be headed by the Director.

''(b) PRIORITIZATION.—

''(1) IN GENERAL.—The Director shall prioritize areas for the identification, development, evaluation, and implementation of best practices (including innovative methodologies and strategies) for quality improvement activities in the delivery of health care services (in this section referred to as 'best practices').

''(2) CONSIDERATIONS.—In prioritizing areas under paragraph (1), the Director shall consider—

''(A) the priorities established under section 1191 of the Social Security Act; and

''(B) the key health indicators identified by the Assistant Secretary for Health Information under section 1709.

''(3) LIMITATIONS.—In conducting its duties under this subsection, the Center for Quality Improvement shall not develop quality-adjusted life year measures or any other methodologies that can be used to deny benefits to a beneficiary against the

beneficiary's wishes on the basis of the beneficiary's age, life expectancy, present or predicted disability, or expected quality of life.

''(c) OTHER RESPONSIBILITIES.—The Director, acting directly or by awarding a grant or contract to an eligible entity, shall—

''(1) identify existing best practices under subsection (e);

''(2) develop new best practices under subsection (f);

''(3) evaluate best practices under subsection (g);

''(4) implement best practices under subsection (h);

''(5) ensure that best practices are identified, developed, evaluated, and implemented under this section consistent with standards adopted by the Secretary under section 3004 for health information technology used in the collection and reporting of quality information (including for purposes of the demonstration of meaningful use of certified electronic health record (EHR) technology by physicians and hospitals under the Medicare program (under sections 1848(o)(2) and 1886(n)(3), respectively, of the Social Security Act)); and

''(6) provide for dissemination of information and reporting under subsections (i) and (j).

''(d) ELIGIBILITY.—To be eligible for a grant or contract under subsection (c), an entity shall—

''(1) be a nonprofit entity;

''(2) agree to work with a variety of institutional health care providers, physicians, nurses, and other health care practitioners; and

''(3) if the entity is not the organization holding a contract under section 1153 of the Social Security Act for the area to be served, agree to cooperate with and avoid duplication of the activities of such organization.

''(e) IDENTIFYING EXISTING BEST PRACTICES.—The Director shall identify best practices that are—

''(1) currently utilized by health care providers (including hospitals, physician and other clinician practices, community cooperatives, and other health care entities) that deliver consistently high-quality, efficient health care services; and

''(2) easily adapted for use by other health care providers and for use across a variety of health care settings.

''(f) DEVELOPING NEW BEST PRACTICES.—The Director shall develop best practices that are—

''(1) based on a review of existing scientific evidence;

''(2) sufficiently detailed for implementation and incorporation into the workflow of health care providers; and

''(3) designed to be easily adapted for use by health care providers across a variety of health care settings.

''(g) EVALUATION OF BEST PRACTICES.—The Director shall evaluate best practices identified or developed under this section. Such evaluation—

''(1) shall include determinations of which best practices—

''(A) most reliably and effectively achieve significant progress in improving the quality of patient care; and

''(B) are easily adapted for use by health care providers across a variety of health care settings;

''(2) shall include regular review, updating, and improvement of such best practices; and

''(3) may include in-depth case studies or empirical assessments of health care providers (including hospitals, physician and other clinician practices, community cooperatives, and other health care enti-

ties) and simulations of such best practices for determinations under paragraph (1).

''(h) IMPLEMENTATION OF BEST PRACTICES.—

''(1) IN GENERAL.—The Director shall enter into arrangements with entities in a State or region to implement best practices identified or developed under this section. Such implementation—

''(A) may include forming collaborative multi-institutional teams; and

''(B) shall include an evaluation of the best practices being implemented, including the measurement of patient outcomes before, during, and after implementation of such best practices.

''(2) PREFERENCES.—In carrying out this subsection, the Director shall give priority to health care providers implementing best practices that—

''(A) have the greatest impact on patient outcomes and satisfaction;

''(B) are the most easily adapted for use by health care providers across a variety of health care settings;

''(C) promote coordination of health care practitioners across the continuum of care; and

''(D) engage patients and their families in improving patient care and outcomes.

''(i) PUBLIC DISSEMINATION OF INFORMATION.—The Director shall provide for the public dissemination of information with respect to best practices and activities under this section. Such information shall be made available in appropriate formats and languages to reflect the varying needs of consumers and diverse levels of health literacy.

''(j) REPORT.—

''(1) IN GENERAL.—The Director shall submit an annual report to the Congress and the Secretary on activities under this section.

''(2) CONTENT.—Each report under paragraph (1) shall include—

''(A) information on activities conducted pursuant to grants and contracts awarded;

''(B) summary data on patient outcomes before, during, and after implementation of best practices; and

''(C) recommendations on the adaptability of best practices for use by health providers.''.

(b) INITIAL QUALITY IMPROVEMENT ACTIVITIES AND INITIATIVES TO BE IMPLEMENTED.—Until the Director of the Agency for Healthcare Research and Quality has

established initial priorities under section 931(b) of the Public Health Service Act, as added by subsection (a), the Director shall, for purposes of such section, prioritize the following:

(1) HEALTH CARE-ASSOCIATED INFECTIONS.—Reducing health care-associated infections, including infections in nursing homes and outpatient settings.

(2) SURGERY.—Increasing hospital and outpatient perioperative patient safety, including reducing surgical-site infections and surgical errors (such as wrong-site surgery and retained foreign bodies).

(3) EMERGENCY ROOM.—Improving care in hospital emergency rooms, including through the use of principles of efficiency of design and delivery to improve patient flow.

(4) OBSTETRICS.—Improving the provision of obstetrical and neonatal care, including the identification of interventions that are effective in reducing the risk of preterm and premature labor and the implementation of best practices for labor and delivery care.

(5) PEDIATRICS.—Improving the provision of preventive and developmental child health services, including interventions that can reduce child health disparities (as defined in section 3171 of the Public

Health Service Act, as added by section 2301) and reduce the risk of developing chronic health-threatening conditions that affect an individual's life course development.

(c) REPORT.—Not later than 18 months after the date of the enactment of this Act, the Director of the Agency for Healthcare Research and Quality shall submit a report to the Congress on the impact of the nurse-to-patient ratio on the quality of care and patient outcomes, including recommendations for further integration into quality measurement and quality improvement activities.

SEC. 2402. ASSISTANT SECRETARY FOR HEALTH INFORMATION.

(a) ESTABLISHMENT.—Title XVII (42 U.S.C. 300u et seq.) is amended—

(1) by redesignating sections 1709 and 1710 as sections 1710 and 1711, respectively; and

(2) by inserting after section 1708 the following:

"SEC. 1709. ASSISTANT SECRETARY FOR HEALTH INFORMATION.

''(a) IN GENERAL.—There is established within the Department an Assistant Secretary for Health Information (in this section referred to as the 'Assistant Secretary'), to be appointed by the Secretary.

''(b) RESPONSIBILITIES.—The Assistant Secretary shall—

''(1) ensure the collection, collation, reporting, and publishing of information (including full and complete statistics) on key health indicators regarding the Nation's health and the performance of the Nation's health care;

''(2) facilitate and coordinate the collection, collation, reporting, and publishing of information regarding the Nation's health and the performance of the Nation's health care (other than information described in paragraph (1));

''(3)(A) develop standards for the collection of data regarding the Nation's health and the performance of the Nation's health care; and

''(B) in carrying out subparagraph (A)—

''(i) ensure appropriate specificity and standardization for data collection at the national, regional, State, and local levels;

''(ii) include standards, as appropriate, for the collection of accurate data on health disparities;

''(iii) ensure, with respect to data on race and ethnicity, consistency with the 1997 Office of Management and Budget Standards for

Maintaining, Collecting and Presenting Federal Data on Race and Ethnicity (or any successor standards); and

''(iv) in consultation with the Director of the Office of Minority Health, and the Director of the Office of Civil Rights of the Department, develop standards for the collection of data on health and health care with respect to primary language;

''(4) provide support to Federal departments and agencies whose programs have a significant impact upon health (as determined by the Secretary) for the collection and collation of information described in paragraphs (1) and (2);

''(5) ensure the sharing of information described in paragraphs (1) and (2) among the agencies of the Department;

''(6) facilitate the sharing of information described in paragraphs (1) and (2) by Federal departments and agencies whose programs have a significant impact upon health (as determined by the Secretary);

''(7) identify gaps in information described in paragraphs (1) and (2) and the appropriate agency or entity to address such gaps;

''(8) facilitate and coordinate identification and monitoring of health disparities by the agencies of the Department to inform program and policy efforts to reduce such disparities, including facilitating and funding analyses conducted in cooperation with the Social Security Administration, the Bureau of the Census, and other appropriate agencies and entities;

''(9) consistent with privacy, proprietary, and other appropriate safeguards, facilitate public accessibility of datasets (such as de-identified Medicare datasets or publicly available data on key health indicators) by means of the Internet; and

''(10) award grants or contracts for the collection and collation of information described in paragraphs (1) and (2) (including through statewide surveys that provide standardized information).

''(c) KEY HEALTH INDICATORS.—

''(1) IN GENERAL.—In carrying out subsection (b)(1), the Assistant Secretary shall—

''(A) identify, and reassess at least once every 3 years, key health indicators described in such subsection;

''(B) publish statistics on such key health indicators for the public—

''(i) not less than annually; and

''(ii) on a supplemental basis whenever warranted by—

''(I) the rate of change for a key health indicator; or

''(II) the need to inform policy regarding the Nation's health and the performance of the Nation's health care; and

''(C) ensure consistency with the national strategy developed by the Secretary under section 3121 and consideration of the indicators specified in the reports under sections 308, 903(a)(6), and 913(b)(2).

''(2) RELEASE OF KEY HEALTH INDICATORS.—The regulations, rules, processes, and procedures of the Office of Management and Budget governing the review, release, and dissemination of key health indicators shall be the same as the regulations, rules, processes, and procedures of the Office of Management and Budget governing the review, release, and dissemination of Principal Federal Economic Indicators (or equivalent statistical data) by the Bureau of Labor Statistics.

''(d) COORDINATION.—In carrying out this section, the Assistant Secretary shall coordinate with—

''(1) public and private entities that collect and disseminate information on health and health care, including foundations; and

''(2) the head of the Office of the National Coordinator for Health Information Technology to ensure optimal use of health information technology.

''(e) REQUEST FOR INFORMATION FROM DEPARTMENTS AND AGENCIES.—Consistent with applicable law, the Assistant Secretary may secure directly from any Federal department or agency information necessary to enable the Assistant Secretary to carry out this section.

''(f) REPORT.—

''(1) SUBMISSION.—The Assistant Secretary shall submit to the Secretary and the Congress an annual report containing—

''(A) a description of national, regional, or State changes in health or health care, as reflected by the key health indicators identified under subsection (c)(1);

''(B) a description of gaps in the collection, collation, reporting, and publishing of information regarding the Nation's health and the performance of the Nation's health care;

''(C) recommendations for addressing such gaps and identification of the appropriate agency within the Department or other entity to address such gaps;

''(D) a description of analyses of health disparities, including the results of completed analyses, the status of ongoing longitudinal studies, and proposed or planned research; and

''(E) a plan for actions to be taken by the Assistant Secretary to address gaps described in subparagraph (B).

''(2) CONSIDERATION.—In preparing a report under paragraph (1), the Assistant Secretary shall take into consideration the findings and conclusions in the reports under sections 308, 903(a)(6), and 913(b)(2).

''(g) PROPRIETARY AND PRIVACY PROTECTIONS.—Nothing in this section shall be construed to affect applicable proprietary or privacy protections.

''(h) CONSULTATION.—In carrying out this section, the Assistant Secretary shall consult with—

''(1) the heads of appropriate health agencies and offices in the Department, including the Office of the Surgeon General of the Public Health Service,

the Office of Minority Health, and the Office on Women's Health; and

''(2) as appropriate, the heads of other Federal departments and agencies whose programs have a significant impact upon health (as determined by the Secretary).

''(i) DEFINITION.—In this section:

''(1) The terms 'agency' and 'agencies' include an epidemiology center established under section 214 of the Indian Health Care Improvement Act.

''(2) The term 'Department' means the Department of Health and Human Services.

''(3) The term 'health disparities' has the meaning given to such term in section 3171.''.

(b) OTHER COORDINATION RESPONSIBILITIES.—Title III (42 U.S.C. 241 et seq.) is amended—

(1) in paragraphs (1) and (2) of section 304(c) (42 U.S.C. 242b(c)), by inserting '', acting through the Assistant Secretary for Health Information,'' after ''The Secretary'' each place it appears; and

(2) in section 306(j) (42 U.S.C. 242k(j)), by inserting '', acting through the Assistant Secretary for Health Information,'' after ''of this section, the Secretary''.

SEC. 2403. AUTHORIZATION OF APPROPRIATIONS.

Section 799C, as added and amended, is further amended by adding at the end the following:

''(e) QUALITY AND SURVEILLANCE.—For the purpose of carrying out part D of title IX and section 1709, in addition to any other amounts authorized to be appropriated for such purpose, there are authorized to be appropriated, out of any monies in the Public Health Investment Fund, $300,000,000 for each of fiscal years 2011 through 2015.''.

TITLE V—OTHER PROVISIONS

Subtitle A—Drug Discount for Rural and Other Hospitals; 340B Program Integrity

SEC. 2501. EXPANDED PARTICIPATION IN 340B PROGRAM.

(a) EXPANSION OF COVERED ENTITIES RECEIVING DISCOUNTED PRICES.—Section 340B(a)(4) (42 U.S.C. 256b(a)(4)) is amended by adding at the end the following:

''(M) A children's hospital excluded from the Medicare prospective payment system pursuant to section 1886(d)(1)(B)(iii) of the Social Security Act, or a free-standing cancer hospital excluded from the Medicare prospective payment system pursuant to section 1886(d)(1)(B)(v) of the Social Security Act

that would meet the requirements of subparagraph (L), including the disproportionate share adjustment percentage requirement under clause (ii) of such subparagraph, if the hospital were a subsection (d) hospital as defined by section 1886(d)(1)(B) of the Social Security Act.

''(N) An entity that is a critical access hospital (as determined under section 1820(c)(2) of the Social Security Act).

''(O) An entity receiving funds under title V of the Social Security Act (relating to maternal and child health) for the provision of health services.

''(P) An entity receiving funds under subpart I of part B of title XIX of the Public Health Service Act (relating to comprehensive mental health services) for the provision of community mental health services.

''(Q) An entity receiving funds under subpart II of such part B (relating to the prevention and treatment of substance abuse) for the provision of treatment services for substance abuse.

''(R) An entity that is a Medicare-dependent, small rural hospital (as defined in section 1886(d)(5)(G)(iv) of the Social Security Act).

''(S) An entity that is a sole community hospital (as defined in section 1886(d)(5)(D)(iii) of the Social Security Act).

''(T) An entity that is classified as a rural referral center under section 1886(d)(5)(C) of the Social Security Act.''.

(b) PROHIBITION ON GROUP PURCHASING ARRANGEMENTS.—Section 340B(a) (42 U.S.C. 256b(a)) is amended—

(1) in paragraph (4)(L)—

(A) by adding ''and'' at the end of clause (i);

(B) by striking ''; and'' at the end of clause (ii) and inserting a period; and

(C) by striking clause (iii); and

(2) in paragraph (5), by redesignating subparagraphs (C) and (D) as subparagraphs (D) and (E), respectively, and by inserting after subparagraph (B) the following:

''(C) PROHIBITING USE OF GROUP PURCHASING ARRANGEMENTS.—A hospital described in subparagraph (L), (M), (N), (R),

(S), or (T) of paragraph (4) shall not obtain covered outpatient drugs through a group purchasing organization or other group purchasing arrangement.''.

SEC. 2502. IMPROVEMENTS TO 340B PROGRAM INTEGRITY.

(a) INTEGRITY IMPROVEMENTS.—Section 340B (42 U.S.C. 256b) is amended—

(1) by striking subsections (c) and (d); and

(2) by inserting after subsection (b) the following:

''(c) IMPROVEMENTS IN PROGRAM INTEGRITY.—

''(1) MANUFACTURER COMPLIANCE.—

''(A) IN GENERAL.—From amounts appropriated under paragraph (4), the Secretary shall provide for improvements in compliance by manufacturers with the requirements of this section in order to prevent overcharges and other violations of the discounted pricing requirements specified in this section.

''(B) IMPROVEMENTS.—The improvements described in subparagraph (A) shall include the following:

''(i) The establishment of a process to enable the Secretary to verify the accuracy of ceiling prices calculated by manufactur-

ers under subsection (a)(1) and charged to covered entities, which shall include the following:

''(I) Developing and publishing, through an appropriate policy or regulatory issuance, standards and methodology for the calculation of ceiling prices under such subsection.

''(II) Comparing regularly the ceiling prices calculated by the Secretary with the quarterly pricing data that is reported by manufacturers to the Secretary.

''(III) Conducting periodic monitoring of sales transactions to covered entities.

''(IV) Inquiring into any discrepancies between ceiling prices and manufacturer pricing data that may be identified and taking, or requiring manufacturers to take, corrective action in response to such discrepancies, including the issuance of refunds pursuant to the procedures set forth in clause (ii).

''(ii) The establishment of procedures for the issuance of refunds to covered entities by manufacturers in the event that the Secretary finds there has been an overcharge, including the following:

''(I) Submission to the Secretary by manufacturers of an explanation of why and how the overcharge occurred, how the refunds will be calculated, and to whom the refunds will be issued.

''(II) Oversight by the Secretary to ensure that the refunds are issued accurately and within a reasonable period of time.

''(iii) Notwithstanding any other provision of law prohibiting the disclosure of ceiling prices or data used to calculate the ceiling price, the provision of access to covered entities and State Medicaid agencies through an Internet website of the Department of Health and Human Services or contractor to the applicable ceiling prices for covered drugs as calculated and verified by the Secretary in a manner that ensures

protection of privileged pricing data from unauthorized disclosure.

''(iv) The development of a mechanism by which—

''(I) rebates, discounts, or other price concessions provided by manufacturers to other purchasers subsequent to the sale of covered drugs to covered entities are reported to the Secretary; and

''(II) appropriate credits and refunds are issued to covered entities if such rebates, discounts, or other price concessions have the effect of lowering the applicable ceiling price for the relevant quarter for the drugs involved.

''(v) In addition to authorities under section 1927(b)(3) of the Social Security Act, the Secretary may conduct audits of manufacturers and wholesalers to ensure the integrity of the program under this section, including audits on the market price of covered drugs.

''(vi) The establishment of a requirement that manufacturers and wholesalers

use the identification system developed by the Secretary for purposes of facilitating the ordering, purchasing, and delivery of covered drugs under this section, including the processing of chargebacks for such drugs.

''(vii) The imposition of sanctions in the form of civil monetary penalties, which—

''(I) shall be assessed according to standards and procedures established in regulations to be promulgated by the Secretary within one year of the date of the enactment of the Affordable Health Care for America Act; and

''(II) shall apply to any manufacturer with an agreement under this section and shall not exceed $100,000 for each instance where a manufacturer knowingly charges a covered entity a price for purchase of a drug that exceeds the maximum applicable price under subsection (a)(1) or that knowingly violates any other provision

of this section, or withholds or provides false information to the Secretary or to covered entities under this section.

''(2) COVERED ENTITY COMPLIANCE.—

''(A) IN GENERAL.—From amounts appropriated under paragraph (4), the Secretary shall provide for improvements in compliance by covered entities with the requirements of this section in order to prevent diversion and violations of the duplicate discount provision and other requirements under subsection (a)(5).

''(B) IMPROVEMENTS.—The improvements described in subparagraph (A) shall include the following:

''(i) The development of procedures to enable and require covered entities to update at least annually the information on the Internet Web site of the Department of Health and Human Services relating to this section.

''(ii) The development of procedures for the Secretary to verify the accuracy of information regarding covered entities that

is listed on the Web site described in clause (i).

''(iii) The development of more detailed guidance describing methodologies and options available to covered entities for billing covered drugs to State Medicaid agencies in a manner that avoids duplicate discounts pursuant to subsection (a)(5)(A).

''(iv) The establishment of a single, universal, and standardized identification system by which each covered entity site can be identified by manufacturers, distributors, covered entities, and the Secretary for purposes of facilitating the ordering, purchasing, and delivery of covered drugs under this section, including the processing of chargebacks for such drugs.

''(v) The imposition of sanctions in the form of civil monetary penalties, which—

''(I) shall be assessed according to standards and procedures established in regulations promulgated by the Secretary;

''(II) shall not exceed $5,000 for each violation; and

''(III) shall apply to any covered entity that knowingly violates subparagraph (a)(5)(B) or knowingly violates any other provision of this section.

''(vi) The exclusion of a covered entity from participation in the program under this section, for a period of time to be determined by the Secretary, in cases in which the Secretary determines, in accordance with standards and procedures established in regulations, that—

''(I) a violation of a requirement of this section was repeated and knowing; and

''(II) imposition of a monetary penalty would be insufficient to reasonably ensure compliance.

''(vii) The referral of matters as appropriate to the Food and Drug Administration, the Office of Inspector General of Department of Health and Human Services, or other Federal agencies.

''(3) ADMINISTRATIVE DISPUTE RESOLUTION PROCESS.—From amounts appropriated under paragraph (4), the Secretary may establish and implement an administrative process for the resolution of the following:

''(A) Claims by covered entities that manufacturers have violated the terms of their agreement with the Secretary under subsection (a)(1).

''(B) Claims by manufacturers that covered entities have violated subsection (a)(5)(A) or (a)(5)(B).

''(4) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this subsection, such sums as may be necessary for fiscal year 2011 and each succeeding fiscal year.''.

(b) CONFORMING AMENDMENTS.—

(1) Section 340B(a) (42 U.S.C. 256b(a)) is amended—

(A) by adding at the end of paragraph (1) the following: ''Such agreement shall require that the manufacturer offer each covered entity covered drugs for purchase at or below the applicable ceiling price if such drug is made available to any other purchaser at any price. Such

agreement shall require that, if the supply of a covered drug is insufficient to meet demand, then the manufacturer may utilize an allocation method that is reported in writing to the Secretary and does not discriminate on the basis of the price paid by covered entities or on any other basis related to an entity's participation in the program under this section. Notwithstanding any other provision of law, if the Secretary requests a manufacturer to enter into a new or amended agreement under this section that complies with current law and if the manufacturer opts not to sign the new or amended agreement, then any existing agreement between the manufacturer and the Secretary under this section is deemed to no longer meet the requirements of this section for purposes of this section and section 1927 of the Social Security Act.''; and

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

''(11) QUARTERLY REPORTS.—An agreement described in paragraph (1) shall require that the manufacturer furnish the Secretary with reports on

a quarterly basis that include the following information:

''(A) The price for each covered drug subject to the agreement that, according to the manufacturer, represents the maximum price that covered entities may permissibly be required to pay for the drug (referred to in this section as the 'ceiling price').

''(B) The component information used to calculate the ceiling price as determined necessary to administer the requirements of the program under this section.

''(C) Rebates, discounts, and other price concessions provided by manufacturers to other purchasers subsequent to the sale of covered drugs to covered entities.''.

(2) Section 1927(a)(5) of the Social Security Act (42 U.S.C. 1396r–8(a)(5)) is amended by striking subparagraph (D).

SEC. 2503. EFFECTIVE DATE.

(a) IN GENERAL.—The amendments made by this subtitle shall take effect on the date of the enactment of this Act, and sections 2501, 2502(a)(1), and 2502(b)(2) shall apply to drugs dispensed on or after such date.

(b) EFFECTIVENESS.—The amendments made by this subtitle shall be effective, and shall be taken into account in determining whether a manufacturer is deemed to meet the requirements of section 340B(a) of the Public Health Service Act (42 U.S.C. 256b(a)), and of section 1927(a)(5) of the Social Security Act (42 U.S.C. 1396r–8(a)(5)), notwithstanding any other provision of law.

Subtitle B—Programs

PART 1—GRANTS FOR CLINICS AND CENTERS

SEC. 2511. SCHOOL-BASED HEALTH CLINICS.

(a) IN GENERAL.—Part Q of title III (42 U.S.C. 280h et seq.) is amended by adding at the end the following:

"SEC. 399Z–1. SCHOOL-BASED HEALTH CLINICS.

''(a) PROGRAM.—The Secretary shall establish a school-based health clinic program consisting of awarding grants to eligible entities to support the operation of school-based health clinics (referred to in this section as 'SBHCs').

''(b) ELIGIBILITY.—To be eligible for a grant under this section, an entity shall—

''(1) be an SBHC (as defined in subsection (l)(3)); and

''(2) submit an application at such time, in such manner, and containing such information as

the Secretary may require, including at a minimum—

''(A) evidence that the applicant meets all criteria necessary to be designated as an SBHC;

''(B) evidence of local need for the services to be provided by the SBHC;

''(C) an assurance that—

''(i) SBHC services will be provided in accordance with Federal, State, and local laws;

''(ii) the SBHC has established and maintains collaborative relationships with other health care providers in the catchment area of the SBHC;

''(iii) the SBHC will provide onsite access during the academic day when school is in session and has an established network of support and access to services with backup health providers when the school or SBHC is closed;

''(iv) the SBHC will be integrated into the school environment and will coordinate health services with appropriate school per-

sonnel and other community providers co-located at the school; and

''(v) the SBHC sponsoring facility assumes all responsibility for the SBHC administration, operations, and oversight; and

''(D) such other information as the Secretary may require.

''(c) USE OF FUNDS.—Funds awarded under a grant under this section—

''(1) may be used for—

''(A) providing training related to the provision of comprehensive primary health services and additional health services;

''(B) the management and operation of SBHC programs, including through subcontracts; and

''(C) the payment of salaries for health professionals and other appropriate SBHC personnel; and

''(2) may not be used to provide abortions.

''(d) CONSIDERATION OF NEED.—In determining the amount of a grant under this section, the Secretary shall take into consideration—

''(1) the financial need of the SBHC;

''(2) State, local, or other sources of funding provided to the SBHC; and

''(3) other factors as determined appropriate by the Secretary.

''(e) PREFERENCES.—In awarding grants under this section, the Secretary shall give preference to SBHCs that have a demonstrated record of service to at least one of the following:

''(1) A high percentage of medically underserved children and adolescents.

''(2) Communities or populations in which children and adolescents have difficulty accessing health and mental health services.

''(3) Communities with high percentages of children and adolescents who are uninsured, underinsured, or eligible for medical assistance under Federal or State health benefits programs (including titles XIX and XXI of the Social Security Act).

''(f) MATCHING REQUIREMENT.—The Secretary may award a grant to an SBHC under this section only if the SBHC agrees to provide, from non-Federal sources, an amount equal to 20 percent of the amount of the grant (which may be provided in cash or in kind) to carry out the activities supported by the grant.

''(g) SUPPLEMENT, NOT SUPPLANT.—The Secretary may award a grant to an SBHC under this section only if the SBHC demonstrates to the satisfaction of the Secretary that funds received through the grant will be expended only to supplement, and not supplant, non-Federal and Federal funds otherwise available to the SBHC for operation of the SBHC (including each activity described in paragraph (1) or (2) of subsection (c)).

''(h) PAYOR OF LAST RESORT.—The Secretary may award a grant to an SBHC under this section only if the SBHC demonstrates to the satisfaction of the Secretary that funds received through the grant will not be expended for any activity to the extent that payment has been made, or can reasonably be expected to be made—

''(1) under any insurance policy;

''(2) under any Federal or State health benefits program (including titles XIX and XXI of the Social Security Act); or

''(3) by an entity which provides health services on a prepaid basis.

''(i) REGULATIONS REGARDING REIMBURSEMENT FOR HEALTH SERVICES.—The Secretary shall issue regulations regarding the reimbursement for health services provided by SBHCs to individuals eligible to receive such services through the program under this section, including

reimbursement under any insurance policy or any Federal or State health benefits program (including titles XIX and XXI of the Social Security Act).

''(j) TECHNICAL ASSISTANCE.—The Secretary shall provide (either directly or by grant or contract) technical and other assistance to SBHCs to assist such SBHCs to meet the requirements of this section. Such assistance may include fiscal and program management assistance, training in fiscal and program management, operational and administrative support, and the provision of information to the SBHCs of the variety of resources available under this title and how those resources can be best used to meet the health needs of the communities served by the SBHCs.

''(k) EVALUATION; REPORT.—The Secretary shall—

''(1) develop and implement a plan for evaluating SBHCs and monitoring quality performances under the awards made under this section; and

''(2) submit to the Congress on an annual basis a report on the program under this section.

''(l) DEFINITIONS.—In this section:

''(1) COMPREHENSIVE PRIMARY HEALTH SERVICES.—The term 'comprehensive primary health services' means the core services offered by SBHCs, which—

''(A) shall include—

''(i) comprehensive health assessments, diagnosis, and treatment of minor, acute, and chronic medical conditions and referrals to, and followup for, specialty care; and

''(ii) mental health assessments, crisis intervention, counseling, treatment, and referral to a continuum of services including emergency psychiatric care, community support programs, inpatient care, and outpatient programs; and

''(B) may include additional services, such as oral health, social, and age-appropriate health education services, including nutritional counseling.

''(2) MEDICALLY UNDERSERVED CHILDREN AND ADOLESCENTS.—The term 'medically underserved children and adolescents' means a population of children and adolescents who are residents of an area designated by the Secretary as an area with a shortage of personal health services and health infrastructure for such children and adolescents.

''(3) SCHOOL-BASED HEALTH CLINIC.—The term 'school-based health clinic' means a health clinic that—

''(A) is located in, or is adjacent to, a school facility of a local educational agency;

''(B) is organized through school, community, and health provider relationships;

''(C) is administered by a sponsoring facility;

''(D) provides comprehensive primary health services during school hours to children and adolescents by health professionals in accordance with State and local laws and regulations, established standards, and community practice; and

''(E) does not perform abortion services.

''(4) SPONSORING FACILITY.—The term 'sponsoring facility' is—

''(A) a hospital;

''(B) a public health department;

''(C) a community health center;

''(D) a nonprofit health care entity whose mission is to provide access to comprehensive primary health care services;

''(E) a local educational agency; or

''(F) a program administered by the Indian Health Service or the Bureau of Indian Affairs or operated by an Indian tribe or a tribal organization under the Indian Self-Determination and Education Assistance Act, a Native Hawaiian entity, or an urban Indian program under title V of the Indian Health Care Improvement Act.

''(m) AUTHORIZATION OF APPROPRIATIONS.—For purposes of carrying out this section, there are authorized to be appropriated $50,000,000 for fiscal year 2011 and such sums as may be necessary for each of fiscal years 2012 through 2015.''.

(b) EFFECTIVE DATE.—The Secretary of Health and Human Services shall begin awarding grants under section 399Z–1 of the Public Health Service Act, as added by subsection (a), not later than July 1, 2010, without regard to whether or not final regulations have been issued under section 399Z–1(i) of such Act.

(c) TERMINATION OF STUDY.—Section 2(b) of the Health Care Safety Net Act of 2008 (42 U.S.C. 254b note) is amended by striking paragraph (2) (relating to a school-based health center study).

SEC. 2512. NURSE-MANAGED HEALTH CENTERS.

Title III (42 U.S.C. 241 et seq.) is amended by adding at the end the following:

"PART S—NURSE-MANAGED HEALTH CENTERS

"SEC. 399FF. NURSE-MANAGED HEALTH CENTERS.

''(a) PROGRAM.—The Secretary, acting through the Administrator of the Health Resources and Services Administration, shall establish a nurse-managed health center program consisting of awarding grants to entities under subsection (b).

''(b) GRANT.—The Secretary shall award grants to entities—

''(1) to plan and develop a nurse-managed health center; or

''(2) to operate a nurse-managed health center.

''(c) USE OF FUNDS.—Amounts received as a grant under subsection (b) may be used for activities including the following:

''(1) Purchasing or leasing equipment.

''(2) Training and technical assistance related to the provision of comprehensive primary care services and wellness services.

''(3) Other activities for planning, developing, or operating, as applicable, a nurse-managed health center.

''(d) ASSURANCES APPLICABLE TO BOTH PLANNING AND OPERATION GRANTS.—

''(1) IN GENERAL.—The Secretary may award a grant under this section to an entity only if the entity demonstrates to the Secretary's satisfaction that—

''(A) nurses, in addition to managing the center, will be adequately represented as providers at the center; and

''(B) not later than 90 days after receiving the grant, the entity will establish a community advisory committee composed of individuals, a majority of whom are being served by the center, to provide input into the nurse-managed health center's operations.

''(2) MATCHING REQUIREMENT.—The Secretary may award a grant under this section to an entity only if the entity agrees to provide, from non-Federal sources, an amount equal to 20 percent of the amount of the grant (which may be provided in cash or in kind) to carry out the activities supported by the grant.

''(3) PAYOR OF LAST RESORT.—The Secretary may award a grant under this section to an entity only if the entity demonstrates to the satisfaction of

the Secretary that funds received through the grant will not be expended for any activity to the extent that payment has been made, or can reasonably be expected to be made—

''(A) under any insurance policy;

''(B) under any Federal or State health benefits program (including titles XIX and XXI of the Social Security Act); or

''(C) by an entity which provides health services on a prepaid basis.

''(4) MAINTENANCE OF EFFORT.—The Secretary may award a grant under this section to an entity only if the entity demonstrates to the satisfaction of the Secretary that—

''(A) funds received through the grant will be expended only to supplement, and not supplant, non-Federal and Federal funds otherwise available to the entity for the activities to be funded through the grant; and

''(B) with respect to such activities, the entity will maintain expenditures of non-Federal amounts for such activities at a level not less than the lesser of such expenditures maintained by the entity for the fiscal year preceding the

fiscal year for which the entity receives the grant.

''(e) ADDITIONAL ASSURANCE FOR PLANNING GRANTS.—The Secretary may award a grant under subsection (b)(1) to an entity only if the entity agrees—

''(1) to assess the needs of the medically underserved populations proposed to be served by the nurse-managed health center; and

''(2) to design services and operations of the nurse-managed health center for such populations based on such assessment.

''(f) ADDITIONAL ASSURANCE FOR OPERATION GRANTS.—The Secretary may award a grant under subsection (b)(2) to an entity only if the entity assures that the nurse-managed health center will provide—

''(1) comprehensive primary care services, wellness services, and other health care services deemed appropriate by the Secretary;

''(2) care without respect to insurance status or income of the patient; and

''(3) direct access to client-centered services offered by advanced practice nurses, other nurses, physicians, physician assistants, or other qualified health professionals.

''(g) TECHNICAL ASSISTANCE.—The Secretary shall provide (either directly or by grant or contract) technical and other assistance to nurse-managed health centers to assist such centers in meeting the requirements of this section. Such assistance may include fiscal and program management assistance, training in fiscal and program management, operational and administrative support, and the provision of information to nurse-managed health centers regarding the various resources available under this section and how those resources can best be used to meet the health needs of the communities served by nurse-managed health centers.

''(h) REPORT.—The Secretary shall submit to the Congress an annual report on the program under this section.

''(i) DEFINITIONS.—In this section:

''(1) COMPREHENSIVE PRIMARY CARE SERVICES.—The term 'comprehensive primary care services' has the meaning given to the term 'required primary health services' in section 330(b)(1).

''(2) MEDICALLY UNDERSERVED POPULATION.—The term 'medically underserved population' has the meaning given to such term in section 330(b)(3).

''(3) NURSE-MANAGED HEALTH CENTER.—The term 'nurse-managed health center' has the meaning given to such term in section 801.

''(4) WELLNESS SERVICES.—The term 'wellness services' means any health-related service or intervention, not including primary care, which is designed to reduce identifiable health risks and increase healthy behaviors intended to prevent the onset of disease or lessen the impact of existing chronic conditions by teaching more effective management techniques that focus on individual self-care and patient-driven decisionmaking.

''(j) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there are authorized to be appropriated such sums as may be necessary for each of fiscal years 2011 through 2015.''.

SEC. 2513. FEDERALLY QUALIFIED BEHAVIORAL HEALTH CENTERS.

Section 1913 (42 U.S.C. 300x–3) is amended—

(1) in subsection (a)(2)(A), by striking ''community mental health services'' and inserting ''behavioral health services (of the type offered by federally qualified behavioral health centers consistent with subsection (c)(3))'';

(2) in subsection (b)—

(A) by striking paragraph (1) and inserting the following:

''(1) services under the plan will be provided only through appropriate, qualified community programs (which may include federally qualified behavioral health centers, child mental health programs, psychosocial rehabilitation programs, mental health peer-support programs, and mental health primary consumer-directed programs); and''; and

(B) in paragraph (2), by striking ''community mental health centers'' and inserting ''federally qualified behavioral health centers''; and

(3) by striking subsection (c) and inserting the following:

''(c) CRITERIA FOR FEDERALLY QUALIFIED BEHAVIORAL HEALTH CENTERS.—

''(1) IN GENERAL.—The Administrator shall certify, and recertify at least every 5 years, federally qualified behavioral health centers as meeting the criteria specified in this subsection.

''(2) REGULATIONS.—Not later than 18 months after the date of the enactment of the Affordable Health Care for America Act, the Administrator shall issue final regulations for certifying centers under paragraph (1).

''(3) CRITERIA.—The criteria referred to in subsection (b)(2) are that the center performs each of the following:

''(A) Provide services in locations that ensure services will be available and accessible promptly and in a manner which preserves human dignity and assures continuity of care.

''(B) Provide services in a mode of service delivery appropriate for the target population.

''(C) Provide individuals with a choice of service options where there is more than one efficacious treatment.

''(D) Employ a core staff of clinical staff that is multidisciplinary and culturally and linguistically competent.

''(E) Provide services, within the limits of the capacities of the center, to any individual residing or employed in the service area of the center.

''(F) Provide, directly or through contract, to the extent covered for adults in the State Medicaid plan and for children in accordance with section 1905(r) of the Social Security Act regarding early and periodic screening, diag-

nosis, and treatment, each of the following services:

''(i) Screening, assessment, and diagnosis, including risk assessment.

''(ii) Person-centered treatment planning or similar processes, including risk assessment and crisis planning.

''(iii) Outpatient clinic mental health services, including screening, assessment, diagnosis, psychotherapy, substance abuse counseling, medication management, and integrated treatment for mental illness and substance abuse which shall be evidence-based (including cognitive behavioral therapy, dialectical behavioral therapy, motivational interviewing, and other such therapies which are evidence-based).

''(iv) Outpatient clinic primary care services, including screening and monitoring of key health indicators and health risk (including screening for diabetes, hypertension, and cardiovascular disease and monitoring of weight, height, body mass index (BMI), blood pressure, blood glucose or HbA1C, and lipid profile).

''(v) Crisis mental health services, including 24-hour mobile crisis teams, emergency crisis intervention services, and crisis stabilization.

''(vi) Targeted case management (services to assist individuals gaining access to needed medical, social, educational, and other services and applying for income security and other benefits to which they may be entitled).

''(vii) Psychiatric rehabilitation services including skills training, assertive community treatment, family psychoeducation, disability self-management, supported employment, supported housing services, therapeutic foster care services, multisystemic therapy, and such other evidence-based practices as the Secretary may require.

''(viii) Peer support and counselor services and family supports.

''(G) Maintain linkages, and where possible enter into formal contracts with, inpatient psychiatric facilities and substance abuse detoxification and residential programs.

''(H) Make available to individuals served by the center, directly, through contract, or through linkages with other programs, each of the following:

''(i) Adult and youth peer support and counselor services.

''(ii) Family support services for families of children with serious mental disorders.

''(iii) Other community or regional services, supports, and providers, including schools, child welfare agencies, juvenile and criminal justice agencies and facilities, housing agencies and programs, employers, and other social services.

''(iv) Onsite or offsite access to primary care services.

''(v) Enabling services, including outreach, transportation, and translation.

''(vi) Health and wellness services, including services for tobacco cessation.''.

PART 2—OTHER GRANT PROGRAMS

SEC. 2521. COMPREHENSIVE PROGRAMS TO PROVIDE EDUCATION TO NURSES AND CREATE A PIPELINE TO NURSING.

(a) PURPOSES.—It is the purpose of this section to authorize grants to—

(1) address the projected shortage of nurses by funding comprehensive programs to create a career ladder to nursing (including certified nurse assistants, licensed practical nurses, licensed vocational nurses, and registered nurses) for incumbent ancillary health care workers;

(2) increase the capacity for educating nurses by increasing both nurse faculty and clinical opportunities through collaborative programs between staff nurse organizations, health care providers, and accredited schools of nursing; and

(3) provide training programs through education and training organizations jointly administered by health care providers and health care labor organizations or other organizations representing staff nurses and frontline health care workers, working in collaboration with accredited schools of nursing and academic institutions.

(b) GRANTS.—Not later than 6 months after the date of the enactment of this Act, the Secretary of Labor (re-

ferred to in this section as the ''Secretary'') shall establish a partnership grant program to award grants to eligible entities to carry out comprehensive programs to provide education to nurses and create a pipeline to nursing for incumbent ancillary health care workers who wish to advance their careers, and to otherwise carry out the purposes of this section.

(c) ELIGIBILITY.—To be eligible for a grant under this section, an entity shall be—

(1) a health care entity that is jointly administered by a health care employer and a labor union representing the health care employees of the employer and that carries out activities using labor-management training funds as provided for under section 302(c)(6) of the Labor Management Relations Act, 1947 (29 U.S.C. 186(c)(6));

(2) an entity that operates a training program that is jointly administered by—

(A) one or more health care providers or facilities, or a trade association of health care providers; and

(B) one or more organizations which represent the interests of direct care health care workers or staff nurses and in which the direct care health care workers or staff nurses have

direct input as to the leadership of the organization;

(3) a State training partnership program that consists of nonprofit organizations that include equal participation from industry, including public or private employers, and labor organizations including joint labor-management training programs, and which may include representatives from local governments, worker investment agency one-stop career centers, community-based organizations, community colleges, and accredited schools of nursing; or

(4) a school of nursing (as defined in section 801 of the Public Health Service Act (42 U.S.C. 296)).

(d) ADDITIONAL REQUIREMENTS FOR HEALTH CARE EMPLOYER DESCRIBED IN SUBSECTION (c).—To be eligible for a grant under this section, a health care employer described in subsection (c) shall demonstrate that it—

(1) has an established program within its facility to encourage the retention of existing nurses;

(2) provides wages and benefits to its nurses that are competitive for its market or that have been collectively bargained with a labor organization; and

(3) supports programs funded under this section through 1 or more of the following:

(A) The provision of paid leave time and continued health coverage to incumbent health care workers to allow their participation in nursing career ladder programs, including certified nurse assistants, licensed practical nurses, licensed vocational nurses, and registered nurses.

(B) Contributions to a joint labor-management training fund which administers the program involved.

(C) The provision of paid release time, incentive compensation, or continued health coverage to staff nurses who desire to work full- or part-time in a faculty position.

(D) The provision of paid release time for staff nurses to enable them to obtain a bachelor of science in nursing degree, other advanced nursing degrees, specialty training, or certification program.

(E) The payment of tuition assistance which is managed by a joint labor-management training fund or other jointly administered program.

(e) OTHER REQUIREMENTS.—

(1) MATCHING REQUIREMENT.—

(A) IN GENERAL.—The Secretary may not make a grant under this section unless the applicant involved agrees, with respect to the costs to be incurred by the applicant in carrying out the program under the grant, to make available non-Federal contributions (in cash or in kind under subparagraph (B)) toward such costs in an amount equal to not less than $1 for each $1 of Federal funds provided in the grant. Such contributions may be made directly or through donations from public or private entities, or may be provided through the cash equivalent of paid release time provided to incumbent worker students.

(B) DETERMINATION OF AMOUNT OF NON-FEDERAL CONTRIBUTION.—Non-Federal contributions required in subparagraph (A) may be in cash or in kind (including paid release time), fairly evaluated, including equipment or services (and excluding indirect or overhead costs). Amounts provided by the Federal Government, or services assisted or subsidized to any significant extent by the Federal Government, may not be included in determining the amount of such non-Federal contributions.

(2) REQUIRED COLLABORATION.—Entities carrying out or overseeing programs carried out with assistance provided under this section shall demonstrate collaboration with accredited schools of nursing which may include community colleges and other academic institutions providing associate's, bachelor's, or advanced nursing degree programs or specialty training or certification programs.

(f) USE OF FUNDS.—Amounts awarded to an entity under a grant under this section shall be used for the following:

(1) To carry out programs that provide education and training to establish nursing career ladders to educate incumbent health care workers to become nurses (including certified nurse assistants, licensed practical nurses, licensed vocational nurses, and registered nurses). Such programs shall include one or more of the following:

(A) Preparing incumbent workers to return to the classroom through English-as-a-second-language education, GED education, precollege counseling, college preparation classes, and support with entry level college classes that are a prerequisite to nursing.

(B) Providing tuition assistance with preference for dedicated cohort classes in community colleges, universities, and accredited schools of nursing with supportive services including tutoring and counseling.

(C) Providing assistance in preparing for and meeting all nursing licensure tests and requirements.

(D) Carrying out orientation and mentorship programs that assist newly graduated nurses in adjusting to working at the bedside to ensure their retention postgraduation, and ongoing programs to support nurse retention.

(E) Providing stipends for release time and continued health care coverage to enable incumbent health care workers to participate in these programs.

(2) To carry out programs that assist nurses in obtaining advanced degrees and completing specialty training or certification programs and to establish incentives for nurses to assume nurse faculty positions on a part-time or full-time basis. Such programs shall include one or more of the following:

(A) Increasing the pool of nurses with advanced degrees who are interested in teaching by funding programs that enable incumbent nurses to return to school.

(B) Establishing incentives for advanced degree bedside nurses who wish to teach in nursing programs so they can obtain a leave from their bedside position to assume a full- or part-time position as adjunct or full-time faculty without the loss of salary or benefits.

(C) Collaboration with accredited schools of nursing which may include community colleges and other academic institutions providing associate's, bachelor's, or advanced nursing degree programs, or specialty training or certification programs, for nurses to carry out innovative nursing programs which meet the needs of bedside nursing and health care providers.

(g) PREFERENCE.—In awarding grants under this section the Secretary shall give preference to programs that—

(1) provide for improving nurse retention;

(2) provide for improving the diversity of the new nurse graduates to reflect changes in the demographics of the patient population;

(3) provide for improving the quality of nursing education to improve patient care and safety;

(4) have demonstrated success in upgrading incumbent health care workers to become nurses or which have established effective programs or pilots to increase nurse faculty; or

(5) are modeled after or affiliated with such programs described in paragraph (4).

(h) EVALUATION.—

(1) PROGRAM EVALUATIONS.—An entity that receives a grant under this section shall annually evaluate, and submit to the Secretary a report on, the activities carried out under the grant and the outcomes of such activities. Such outcomes may include—

(A) an increased number of incumbent workers entering an accredited school of nursing and in the pipeline for nursing programs;

(B) an increasing number of graduating nurses and improved nurse graduation and licensure rates;

(C) improved nurse retention;

(D) an increase in the number of staff nurses at the health care facility involved;

(E) an increase in the number of nurses with advanced degrees in nursing;

(F) an increase in the number of nurse faculty;

(G) improved measures of patient quality (which may include staffing ratios of nurses, patient satisfaction rates, and patient safety measures); and

(H) an increase in the diversity of new nurse graduates relative to the patient population.

(2) GENERAL REPORT.—Not later than 2 years after the date of the enactment of this Act, and annually thereafter, the Secretary of Labor shall, using data and information from the reports received under paragraph (1), submit to the Congress a report concerning the overall effectiveness of the grant program carried out under this section.

(i) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section such sums as may be necessary for each of fiscal years 2011 through 2015.

SEC. 2522. MENTAL AND BEHAVIORAL HEALTH TRAINING.

Part E of title VII (42 U.S.C. 294n et seq.) is amended by adding at the end the following:

"Subpart 3—Mental and Behavioral Health Training

"SEC. 775. MENTAL AND BEHAVIORAL HEALTH TRAINING PROGRAM.

''(a) PROGRAM.—The Secretary, acting through the Administrator of the Health Resources and Services Administration and in consultation with the Administrator of the Substance Abuse and Mental Health Services Administration, shall establish an interdisciplinary mental and behavioral health training program consisting of awarding grants and contracts under subsection (b).

''(b) SUPPORT AND DEVELOPMENT OF MENTAL AND BEHAVIORAL HEALTH TRAINING PROGRAMS.—The Secretary shall make grants to, or enter into contracts with, eligible entities—

''(1) to plan, develop, operate, or participate in an accredited professional training program for mental and behavioral health professionals to promote—

''(A) interdisciplinary training; and

''(B) coordination of the delivery of health care within and across settings, including health care institutions, community-based settings, and the patient's home;

''(2) to provide financial assistance to mental and behavioral health professionals, who are participants in any such program, and who plan to work in the field of mental and behavioral health;

''(3) to plan, develop, operate, or participate in an accredited program for the training of mental and behavioral health professionals who plan to teach in the field of mental and behavioral health; and

''(4) to provide financial assistance in the form of traineeships and fellowships to mental and behavioral health professionals who are participants in any such program and who plan to teach in the field of mental and behavioral health.

''(c) ELIGIBILITY.—To be eligible for a grant or contract under subsection (b), an entity shall be—

''(1) an accredited health professions school, including an accredited school or program of psychology, psychiatry, social work, marriage and family therapy, professional mental health or substance abuse counseling, or addiction medicine;

''(2) an accredited public or nonprofit private hospital;

''(3) a public or private nonprofit entity; or

''(4) a consortium of 2 or more entities described in paragraphs (1) through (3).

''(d) PREFERENCE.—In awarding grants or contracts under this section, the Secretary shall give preference to

entities that have a demonstrated record of at least one of the following:

''(1) Training a high or significantly improved percentage of health professionals who serve in underserved communities.

''(2) Supporting teaching programs that address the health care needs of vulnerable populations.

''(3) Training individuals who are from disadvantaged backgrounds (including racial and ethnic minorities underrepresented among mental and behavioral health professionals).

''(4) Training individuals who serve geriatric populations with an emphasis on underserved elderly.

''(5) Training individuals who serve pediatric populations with an emphasis on underserved children.

''(e) REPORT.—The Secretary shall submit to the Congress an annual report on the program under this section.

''(f) DEFINITION.—In this section:

''(1) The term 'interdisciplinary' means collaboration across health professions, specialties, and subspecialties, which may include public health, nursing,

allied health, dietetics or nutrition, and appropriate health specialties.

''(2) The term 'mental and behavioral health professional' means an individual training or practicing—

''(A) in psychology; general, geriatric, child or adolescent psychiatry; social work; marriage and family therapy; professional mental health or substance abuse counseling; or addiction medicine; or

''(B) another mental and behavioral health specialty, as deemed appropriate by the Secretary.

''(g) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there is authorized to be appropriated $60,000,000 for each of fiscal years 2011 through 2015. Of the amounts appropriated to carry out this section for a fiscal year, not less than 15 percent shall be used for training programs in psychology.''.

SEC. 2523. REAUTHORIZATION OF TELEHEALTH AND TELEMEDICINE GRANT PROGRAMS.

(a) TELEHEALTH NETWORK AND TELEHEALTH RESOURCE CENTERS GRANT PROGRAMS.—Section 330I (42 U.S.C. 254c–14) is amended—

(1) in subsection (a)—

(A) by striking paragraph (3) (relating to frontier communities); and

(B) by inserting after paragraph (2) the following:

''(3) HEALTH DISPARITIES.—The term 'health disparities' has the meaning given such term in section 3171.'';

(2) in subsection (d)(1)—

(A) in subparagraph (B), by striking ''and'' at the end;

(B) in subparagraph (C), by striking the period at the end and inserting ''; and''; and

(C) by adding at the end the following:

''(D) reduce health disparities.'';

(3) in subsection (f)(1)(B)(iii)—

(A) in subclause (VII), by inserting '', including skilled nursing facilities'' before the period at the end;

(B) in subclause (IX), by inserting '', including county mental health and public mental health facilities'' before the period at the end; and

(C) by adding at the end the following:

''(XIII) Renal dialysis facilities.'';

(4) by amending subsection (i) to read as follows:

''(i) PREFERENCES.—

''(1) TELEHEALTH NETWORKS.—In awarding grants under subsection (d)(1) for projects involving telehealth networks, the Secretary shall give preference to eligible entities meeting at least one of the following:

''(A) NETWORK.—The eligible entity is a health care provider in, or proposing to form, a health care network that furnishes services in a medically underserved area or a health professional shortage area.

''(B) BROAD GEOGRAPHIC COVERAGE.—The eligible entity demonstrates broad geographic coverage in the rural or medically underserved areas of the State or States in which the entity is located.

''(C) HEALTH DISPARITIES.—The eligible entity demonstrates how the project to be funded through the grant will address health disparities.

''(D) LINKAGES.—The eligible entity agrees to use the grant to establish or develop plans for telehealth systems that will link rural

hospitals and rural health care providers to other hospitals, health care providers, and patients.

''(E) EFFICIENCY.—The eligible entity agrees to use the grant to promote greater efficiency in the use of health care resources.

''(F) VIABILITY.—The eligible entity demonstrates the long-term viability of projects through—

''(i) availability of non-Federal funding sources; or

''(ii) institutional and community support for the telehealth network.

''(G) SERVICES.—The eligible entity provides a plan for coordinating system use by eligible entities and prioritizes use of grant funds for health care services over nonclinical uses.

''(2) TELEHEALTH RESOURCE CENTERS.—In awarding grants under subsection (d)(2) for projects involving telehealth resource centers, the Secretary shall give preference to eligible entities meeting at least one of the following:

''(A) PROVISION OF A BROAD RANGE OF SERVICES.—The eligible entity has a record of success in the provision of a broad range of

telehealth services to medically underserved areas or populations.

''(B) PROVISION OF TELEHEALTH TECHNICAL ASSISTANCE.—The eligible entity has a record of success in the provision of technical assistance to providers serving medically underserved communities or populations in the establishment and implementation of telehealth services.

''(C) COLLABORATION AND SHARING OF EXPERTISE.—The eligible entity has a demonstrated record of collaborating and sharing expertise with providers of telehealth services at the national, regional, State, and local levels.'';

(5) in subsection (j)(2)(B), by striking ''such projects for fiscal year 2001'' and all that follows through the period and inserting ''such projects for fiscal year 2010.'';

(6) in subsection (k)(1)—

(A) in subparagraph (E)(i), by striking ''transmission of medical data'' and inserting ''transmission and electronic archival of medical data''; and

(B) by amending subparagraph (F) to read as follows:

''(F) developing projects to use telehealth technology to—

''(i) facilitate collaboration between health care providers;

''(ii) promote telenursing services; or

''(iii) promote patient understanding and adherence to national guidelines for chronic disease and self-management of such conditions;'';

(7) in subsection (q), by striking ''Not later than September 30, 2005'' and inserting ''Not later than 1 year after the date of the enactment of the Affordable Health Care for America Act, and annually thereafter'';

(8) by striking subsection (r);

(9) by redesignating subsection (s) as subsection (r); and

(10) in subsection (r) (as so redesignated)—

(A) in paragraph (1)—

(i) by striking ''and'' before ''such sums''; and

(ii) by inserting '', $10,000,000 for fiscal year 2011, and such sums as may be necessary for each of fiscal years 2012 through 2015'' before the semicolon; and

(B) in paragraph (2)—

(i) by striking ''and'' before ''such sums''; and

(ii) by inserting '', $10,000,000 for fiscal year 2011, and such sums as may be necessary for each of fiscal years 2012 through 2015'' before the period.

(b) TELEMEDICINE; INCENTIVE GRANTS REGARDING COORDINATION AMONG STATES.—Subsection (b) of section 330L (42 U.S.C. 254c–18) is amended by inserting '', $10,000,000 for fiscal year 2011, and such sums as may be necessary for each of fiscal years 2012 through 2015'' before the period at the end.

SEC. 2524. NO CHILD LEFT UNIMMUNIZED AGAINST INFLUENZA: DEMONSTRATION PROGRAM USING ELEMENTARY AND SECONDARY SCHOOLS AS INFLUENZA VACCINATION CENTERS.

(a) PURPOSE.—The Secretary of Health and Human Services in consultation with the Secretary of Education, shall award grants to eligible partnerships to carry out demonstration programs designed to test the feasibility of using the Nation's elementary schools and secondary schools as influenza vaccination centers.

(b) IN GENERAL.—The Secretary shall coordinate with the Secretary of Labor, the Secretary of Education,

State Medicaid agencies, State insurance agencies, and private insurers to carry out a program consisting of awarding grants under subsection (c) to ensure that children have coverage for all reasonable and customary expenses related to influenza vaccinations, including the costs of purchasing and administering the vaccine incurred when influenza vaccine is administered outside of the physician's office in a school or other related setting.

(c) PROGRAM DESCRIPTION.—

(1) GRANTS.—From amounts appropriated pursuant to subsection (l), the Secretary shall award grants to eligible partnerships to be used to provide influenza vaccinations to children in elementary and secondary schools, in coordination with school nurses, school health care programs, community health care providers, State insurance agencies, or private insurers.

(2) ACIP RECOMMENDATIONS.—The program under this section shall be designed to administer vaccines consistent with the recommendations of the Centers for Disease Control and Prevention's Advisory Committee on Immunization Practices (ACIP) for the annual vaccination of all children 5 through 19 years of age.

(3) PARTICIPATION VOLUNTARY.—Participation by a school or an individual shall be voluntary.

(d) USE OF FUNDS.—Eligible partnerships receiving a grant under this section shall ensure the maximum number of children access influenza vaccinations as follows:

(1) COVERED CHILDREN.—To the extent to which payment of the costs of purchasing or administering the influenza vaccine for children is not covered through other federally funded programs or through private insurance, eligible partnerships receiving a grant shall use funds to purchase and administer influenza vaccinations.

(2) CHILDREN COVERED BY OTHER FEDERAL PROGRAMS.—For children who are eligible under other federally funded programs for payment of the costs of purchasing or administering the influenza vaccine, eligible partnerships receiving a grant shall not use funds provided under this section for such costs.

(3) CHILDREN COVERED BY PRIVATE HEALTH INSURANCE.—For children who have private insurance, eligible partnerships receiving a grant shall offer assistance in accessing coverage for vaccinations administered through the program under this section.

(e) PRIVACY.—The Secretary shall ensure that the program under this section adheres to confidentiality and privacy requirements of section 264 of the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. 1320d–2 note) and section 444 of the General Education Provisions Act (20 U.S.C. 1232g; commonly referred to as the ''Family Educational Rights and Privacy Act of 1974'').

(f) APPLICATION.—An eligible partnership desiring a grant under this section shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require.

(g) DURATION.—Eligible partnerships receiving a grant shall administer a demonstration program funded through this section over a period of 2 consecutive school years.

(h) CHOICE OF VACCINE.—The program under this section shall not restrict the discretion of a health care provider to administer any influenza vaccine approved by the Food and Drug Administration for use in pediatric populations.

(i) AWARDS.—The Secretary shall award—

(1) a minimum of 10 grants in 10 different States to eligible partnerships that each include one

or more public schools serving primarily low-income students; and

(2) a minimum of 5 grants in 5 different States to eligible partnerships that each include one or more public schools located in a rural local educational agency.

(j) REPORT.—Not later than 90 days following the completion of the program under this section, the Secretary shall submit to the Committees on Education and Labor, Energy and Commerce, and Appropriations of the House of Representatives and to the Committees on Health, Education, Labor, and Pensions and Appropriations of the Senate a report on the results of the program. The report shall include—

(1) an assessment of the influenza vaccination rates of school-age children in localities where the program is implemented, compared to the national average influenza vaccination rates for school-aged children, including whether school-based vaccination assists in achieving the recommendations of the Advisory Committee on Immunization Practices;

(2) an assessment of the utility of employing elementary schools and secondary schools as a part of a multistate, community-based pandemic response

program that is consistent with existing Federal and State pandemic response plans;

(3) an assessment of the feasibility of using existing Federal and private insurance funding in establishing a multistate, school-based vaccination program for seasonal influenza vaccination;

(4) an assessment of the number of education days gained by students as a result of seasonal vaccinations based on absenteeism rates;

(5) a determination of whether the program under this section—

(A) increased vaccination rates in the participating localities; and

(B) was implemented for sufficient time for gathering enough valid data; and

(6) a recommendation on whether the program should be continued, expanded, or terminated.

(k) DEFINITIONS.—In this section:

(1) ELIGIBLE PARTNERSHIP.—The term ''eligible partnership'' means a local public health department, or another health organization defined by the Secretary as eligible to submit an application, and one or more elementary and secondary schools.

(2) ELEMENTARY SCHOOL.—The terms ''elementary school'' and ''secondary school'' have the

meanings given such terms in section 9101 of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 7801).

(3) LOW-INCOME.—The term ''low-income'' means a student, age 5 through 19, eligible for free or reduced-price lunch under the National School Lunch Act (42 U.S.C. 1751 et seq.).

(4) RURAL LOCAL EDUCATIONAL AGENCY.—The term ''rural local educational agency'' means an eligible local educational agency described in section 6211(b)(1) of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 7345(b)(1)).

(5) SECRETARY.—Except as otherwise specified, the term ''Secretary'' means the Secretary of Health and Human Services.

(l) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there are authorized to be appropriated such sums as may be necessary for each of fiscal years 2011 through 2015.

SEC. 2525. EXTENSION OF WISEWOMAN PROGRAM.

Section 1509 of the Public Health Service Act (42 U.S.C. 300n–4a) is amended—

(1) in subsection (a)—

(A) by striking the heading and inserting ''IN GENERAL.—''; and

(B) in the matter preceding paragraph (1), by striking ''may make grants'' and all that follows through ''purpose'' and inserting the following: ''may make grants to such States for the purpose''; and

(2) in subsection (d)(1), by striking ''there are authorized'' and all that follows through the period and inserting ''there are authorized to be appropriated $70,000,000 for fiscal year 2011, $73,500,000 for fiscal year 2012, $77,000,000 for fiscal year 2013, $81,000,000 for fiscal year 2014, and $85,000,000 for fiscal year 2015.''.

SEC. 2526. HEALTHY TEEN INITIATIVE TO PREVENT TEEN PREGNANCY.

Part B of title III (42 U.S.C. 243 et seq.) is amended by inserting after section 317T the following:

''SEC. 317U. HEALTHY TEEN INITIATIVE TO PREVENT TEEN PREGNANCY.

''(a) PROGRAM.—To the extent and in the amount of appropriations made in advance in appropriations Acts, the Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall establish a program consisting of making grants, in amounts determined under subsection (c), to each State that submits an appli-

cation in accordance with subsection (d) for an evidence-based education program described in subsection (b).

''(b) USE OF FUNDS.—Amounts received by a State under this section shall be used to conduct or support evidence-based education programs (directly or through grants or contracts to public or private nonprofit entities, including schools and community-based and faith-based organizations) to reduce teen pregnancy or sexually transmitted diseases.

''(c) DISTRIBUTION OF FUNDS.—The Director shall, for fiscal year 2011 and each subsequent fiscal year, make a grant to each State described in subsection (a) in an amount equal to the product of—

''(1) the amount appropriated to carry out this section for the fiscal year; and

''(2) the percentage determined for the State under section 502(c)(1)(B)(ii) of the Social Security Act.

''(d) APPLICATION.—To seek a grant under this section, a State shall submit an application at such time, in such manner, and containing such information and assurance of compliance with this section as the Secretary may require. At a minimum, an application shall to the satisfaction of the Secretary—

''(1) describe how the State's proposal will address the needs of at-risk teens in the State;

''(2) identify the evidence-based education program or programs selected from the registry developed under subsection (g) that will be used to address risks in priority populations;

''(3) describe how the program or programs will be implemented and any adaptations to the evidence-based model that will be made;

''(4) list any private and public entities with whom the State proposes to work, including schools and community-based and faith-based organizations, and demonstrate their capacity to implement the proposed program or programs; and

''(5) identify an independent entity that will evaluate the impact of the program or programs.

''(e) EVALUATION.—

''(1) REQUIREMENT.—As a condition on receipt of a grant under this section, a State shall agree—

''(A) to arrange for an independent evaluation of the impact of the programs to be conducted or supported through the grant; and

''(B) submit reports to the Secretary on such programs and the results of evaluation of such programs.

''(2) FUNDING LIMITATION.—Of the amounts made available to a State through a grant under this section for any fiscal year, not more than 10 percent may be used for such evaluation.

''(f) RULE OF CONSTRUCTION.—This section shall not be construed to preempt or limit any State law regarding parental involvement and decisionmaking in children's education.

''(g) REGISTRY OF ELIGIBLE PROGRAMS.—The Secretary shall develop not later than 180 days after the date of the enactment of the Affordable Health Care for America Act, and periodically update thereafter, a publicly available registry of programs described in subsection (b) that, as determined by the Secretary—

''(1) meet the definition of the term 'evidence-based' in subsection (i);

''(2) are medically and scientifically accurate; and

''(3) provide age-appropriate information.

''(h) MATCHING FUNDS.—The Secretary may award a grant to a State under this section for a fiscal year only if the State agrees to provide, from non-Federal sources, an amount equal to $1 (in cash or in kind) for each $4 provided through the grant to carry out the activities supported by the grant.

''(i) DEFINITION.—In this section, the term 'evidence-based' means based on a model that has been found, in methodologically sound research—

''(1) to delay initiation of sex;

''(2) to decrease number of partners;

''(3) to reduce teen pregnancy;

''(4) to reduce sexually transmitted infection rates; or

''(5) to improve rates of contraceptive use.

''(j) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there is authorized to be appropriated $50,000,000 for each of fiscal years 2011 through 2015.''.

SEC. 2527. NATIONAL TRAINING INITIATIVES ON AUTISM SPECTRUM DISORDERS.

Title I of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15001 et seq.) is amended by adding at the end the following:

"Subtitle F—National Training Initiative on Autism Spectrum Disorders

"SEC. 171. NATIONAL TRAINING INITIATIVE.

''(a) GRANTS AND TECHNICAL ASSISTANCE.—

''(1) GRANTS.—

''(A) IN GENERAL.—The Secretary, in consultation with the Interagency Autism Coordinating Committee, shall award multiyear grants to eligible entities to provide individuals (including parents and health, allied health, vocational, and educational professionals) with interdisciplinary training, continuing education, technical assistance, and information for the purpose of improving services rendered to children and adults with autism, and their families, to address unmet needs related to autism.

''(B) ELIGIBLE ENTITY.—To be eligible to receive a grant under this subsection, an entity shall be—

''(i) a University Center for Excellence in Developmental Disabilities Education, Research, and Service; or

''(ii) a comparable interdisciplinary education, research, and service entity.

''(C) APPLICATION REQUIREMENTS.—An entity that desires to receive a grant for a program under this paragraph shall submit to the Secretary an application—

''(i) demonstrating that the entity has capacity to—

''(I) provide training and technical assistance in evidence-based practices to evaluate, and provide effective interventions, services, treatments, and supports to, children and adults with autism and their families;

''(II) include individuals with autism and their families as part of the program to ensure that an individual- and family-centered approach is used;

''(III) share and disseminate materials and practices that are developed for, and evaluated to be effective in, the provision of training and technical assistance; and

''(IV) provide training, technical assistance, interventions, services, treatments, and supports under this subsection statewide.

''(ii) providing assurances that the entity will—

''(I) provide trainees under this subsection with an appropriate balance of interdisciplinary academic and community-based experiences; and

''(II) provide to the Secretary, in the manner prescribed by the Secretary, data regarding the number of individuals who have benefitted from, and outcomes of, the provision of training and technical assistance under this subsection;

''(iii) providing assurances that training, technical assistance, dissemination of information, and services under this subsection will be—

''(I) consistent with the goals of this Act, the Americans with Disabilities Act of 1990, the Individuals with Disabilities Education Act, and the Elementary and Secondary Education Act of 1965; and

''(II) conducted in coordination with relevant State agencies, institutions of higher education, and service providers; and

''(iv) containing such other information and assurances as the Secretary may require.

''(D) USE OF FUNDS.—A grant received under this subsection shall be used to provide individuals (including parents and health, allied health, vocational, and educational professionals) with interdisciplinary training, continuing education, technical assistance, and information for the purpose of improving services rendered to children and adults with autism, and their families, to address unmet needs related to autism. Such training, education, assistance, and information shall include each of the following:

''(i) Training health, allied health, vocational, and educational professionals to identify, evaluate the needs of, and develop interventions, services, treatments, and supports for, children and adults with autism.

''(ii) Developing model services and supports that demonstrate evidence-based practices.

''(iii) Developing systems and products that allow for the interventions, services, treatments, and supports to be evaluated for fidelity of implementation.

''(iv) Working to expand the availability of evidence-based, lifelong interventions; educational, employment, and transition services; and community supports.

''(v) Providing statewide technical assistance in collaboration with relevant State agencies, institutions of higher education, autism advocacy groups, and community-based service providers.

''(vi) Working to develop comprehensive systems of supports and services for individuals with autism and their families, including seamless transitions between education and health systems across the lifespan.

''(vii) Promoting training, technical assistance, dissemination of information, supports, and services.

''(viii) Developing mechanisms to provide training and technical assistance, including for-credit courses, intensive summer institutes, continuing education programs, distance based programs, and Web-based information dissemination strategies.

''(ix) Promoting activities that support community-based family and individual services and enable individuals with autism and related developmental disabilities to fully participate in society and achieve good quality-of-life outcomes.

''(x) Collecting data on the outcomes of training and technical assistance programs to meet statewide needs for the expansion of services to children and adults with autism.

''(E) AMOUNT OF GRANTS.—The amount of a grant to any entity for a fiscal year under this section shall be not less than $250,000.

''(2) TECHNICAL ASSISTANCE.—The Secretary shall reserve 2 percent of the amount appropriated to carry out this subsection for a fiscal year to make a grant to a national organization with demonstrated capacity for providing training and technical assistance to—

''(A) assist in national dissemination of specific information, including evidence-based best practices, from interdisciplinary training programs, and when appropriate, other entities

whose findings would inform the work performed by entities awarded grants;

''(B) compile and disseminate strategies and materials that prove to be effective in the provision of training and technical assistance so that the entire network can benefit from the models, materials, and practices developed in individual centers;

''(C) assist in the coordination of activities of grantees under this subsection;

''(D) develop a Web portal that will provide linkages to each of the individual training initiatives and provide access to training modules, promising training, and technical assistance practices and other materials developed by grantees;

''(E) serve as a research-based resource for Federal and State policymakers on information concerning the provision of training and technical assistance for the assessment, and provision of supports and services for, children and adults with autism;

''(F) convene experts from multiple interdisciplinary training programs, individuals with autism, and the families of such individuals to

discuss and make recommendations with regard to training issues related to assessment, interventions, services, treatment, and supports for children and adults with autism; and

''(H) undertake any other functions that the Secretary determines to be appropriate.

''(3) AUTHORIZATION OF APPROPRIATIONS.—To carry out this subsection, there are authorized to be appropriated $17,000,000 for fiscal year 2011 and such sums as may be necessary for each of fiscal years 2012 through 2015.

''(b) EXPANSION OF THE NUMBER OF UNIVERSITY CENTERS FOR EXCELLENCE IN DEVELOPMENTAL DISABILITIES EDUCATION, RESEARCH, AND SERVICE.—

''(1) GRANTS.—To provide for the establishment of up to 4 new University Centers for Excellence in Developmental Disabilities Education, Research, and Service, the Secretary shall award up to 4 grants to institutions of higher education.

''(2) APPLICABLE PROVISIONS.—Except for subsection (a)(3), the provisions of subsection (a) shall apply with respect to grants under this subsection to the same extent and in the same manner as such provisions apply with respect to grants under subsection (a).

''(3) PRIORITY.—In awarding grants under this subsection, the Secretary shall give priority to applicants that—

''(A) are minority institutions that have demonstrated capacity to meet the requirements of this section and provide services to individuals with autism and their families; or

''(B) are located in a State with one or more underserved populations.

''(4) AUTHORIZATION OF APPROPRIATIONS.—To carry out this subsection, there is authorized to be appropriated $2,000,000 for each of fiscal years 2011 through 2015.

''(c) DEFINITIONS.—In this section:

''(1) The term 'autism' means an autism spectrum disorder or a related developmental disability.

''(2) The term 'interventions' means educational methods and positive behavioral support strategies designed to improve or ameliorate symptoms associated with autism.

''(3) The term 'minority institution' has the meaning given to such term in section 365 of the Higher Education Act of 1965.

''(4) The term 'services' means services to assist individuals with autism to live more independently in their communities.

''(5) The term 'treatments' means health services, including mental health services, designed to improve or ameliorate symptoms associated with autism.

''(6) The term 'University Center for Excellence in Developmental Disabilities Education, Research, and Service' means a University Center for Excellence in Development Disabilities Education, Research, and Service that has been or is funded through subtitle D or subsection (b).''.

SEC. 2528. IMPLEMENTATION OF MEDICATION MANAGEMENT SERVICES IN TREATMENT OF CHRONIC DISEASES.

(a) IN GENERAL.—The Secretary of Health and Human Services (referred to in this section as the ''Secretary''), acting through the Director of the Agency for Health Care Research and Quality, shall establish a program to provide grants to eligible entities to implement medication management services (referred to in this section as ''MTM services'') provided by licensed pharmacists, as a part of a collaborative, multidisciplinary, interprofessional approach to the treatment of chronic dis-

eases for targeted individuals, to improve the quality of care and reduce overall cost in the treatment of such diseases. The Secretary shall commence the grant program not later than May 1, 2011.

(b) ELIGIBLE ENTITIES.—To be eligible to receive a grant under subsection (a), an entity shall—

(1) provide a setting appropriate for MTM services, as recommended by the experts described in subsection (e);

(2) submit to the Secretary a plan for achieving long-term financial sustainability;

(3) where applicable, submit a plan for coordinating MTM services with other local providers and where applicable, through or in collaboration with the Medicare Medical Home Pilot program as established by section 1866F of the Social Security Act, as added by section 1302(a) of this Act;

(4) submit a plan for meeting the requirements under subsection (c); and

(5) submit to the Secretary such other information as the Secretary may require.

(c) MTM SERVICES TO TARGETED INDIVIDUALS.—The MTM services provided with the assistance of a grant awarded under subsection (a) shall, as allowed by State

law (including applicable collaborative pharmacy practice agreements), include—

(1) performing or obtaining necessary assessments of the health and functional status of each patient receiving such MTM services;

(2) formulating a medication treatment plan according to therapeutic goals agreed upon by the prescriber and the patient or caregiver or authorized representative of the patient;

(3) selecting, initiating, modifying, recommending changes to, or administering medication therapy;

(4) monitoring, which may include access to, ordering, or performing laboratory assessments, and evaluating the response of the patient to therapy, including safety and effectiveness;

(5) performing an initial comprehensive medication review to identify, resolve, and prevent medication-related problems, including adverse drug events, quarterly targeted medication reviews for ongoing monitoring, and additional followup interventions on a schedule developed collaboratively with the prescriber;

(6) documenting the care delivered and communicating essential information about such care (in-

cluding a summary of the medication review) and the recommendations of the pharmacist to other appropriate health care providers of the patient in a timely fashion;

(7) providing education and training designed to enhance the understanding and appropriate use of the medications by the patient, caregiver, and other authorized representative;

(8) providing information, support services, and resources and strategies designed to enhance patient adherence with therapeutic regimens;

(9) coordinating and integrating MTM services within the broader health care management services provided to the patient; and

(10) such other patient care services as are allowed under the scopes of practice for pharmacists for purposes of other Federal programs.

(d) TARGETED INDIVIDUALS.—MTM services provided by licensed pharmacists under a grant awarded under subsection (a) shall be offered to targeted individuals who—

(1) take 4 or more prescribed medications (including over-the-counter and dietary supplements);

(2) take any high-risk medications;

(3) have 2 or more chronic diseases, as identified by the Secretary; or

(4) have undergone a transition of care, or other factors, as determined by the Secretary, that are likely to create a high risk of medication-related problems.

(e) CONSULTATION WITH EXPERTS.—In designing and implementing MTM services provided under grants awarded under subsection (a), the Secretary shall consult with Federal, State, private, public-private, and academic entities, pharmacy and pharmacist organizations, health care organizations, consumer advocates, chronic disease groups, and other stakeholders involved with the research, dissemination, and implementation of pharmacist-delivered MTM services, as the Secretary determines appropriate. The Secretary, in collaboration with this group, shall determine whether it is possible to incorporate rapid cycle process improvement concepts in use in other Federal programs that have implemented MTM services.

(f) REPORTING TO THE SECRETARY.—An entity that receives a grant under subsection (a) shall submit to the Secretary a report that describes and evaluates, as requested by the Secretary, the activities carried out under subsection (c), including quality measures, as determined by the Secretary.

(g) EVALUATION AND REPORT.—The Secretary shall submit to the relevant committees of Congress a report which shall—

(1) assess the clinical effectiveness of pharmacist-provided services under the MTM services program, as compared to usual care, including an evaluation of whether enrollees maintained better health with fewer hospitalizations and emergency room visits than similar patients not enrolled in the program;

(2) assess changes in overall health care resource of targeted individuals;

(3) assess patient and prescriber satisfaction with MTM services;

(4) assess the impact of patient-cost-sharing requirements on medication adherence and recommendations for modifications;

(5) identify and evaluate other factors that may impact clinical and economic outcomes, including demographic characteristics, clinical characteristics, and health services use of the patient, as well as characteristics of the regimen, pharmacy benefit, and MTM services provided; and

(6) evaluate the extent to which participating pharmacists who maintain a dispensing role have a

conflict of interest in the provision of MTM services, and if such conflict is found, provide recommendations on how such a conflict might be appropriately addressed.

(h) GRANT TO FUND DEVELOPMENT OF PERFORMANCE MEASURES.—The Secretary may award grants or contracts to eligible entities for the purpose of funding the development of performance measures that assess the use and effectiveness of medication therapy management services.

SEC. 2529. POSTPARTUM DEPRESSION.

(a) EXPANSION AND INTENSIFICATION OF ACTIVITIES.—

(1) CONTINUATION OF ACTIVITIES.—The Secretary is encouraged to expand and intensify activities on postpartum conditions.

(2) PROGRAMS FOR POSTPARTUM CONDITIONS.—In carrying out paragraph (1), the Secretary is encouraged to continue research to expand the understanding of the causes of, and treatments for, postpartum conditions, including conducting and supporting the following:

(A) Basic research concerning the etiology and causes of the conditions.

(B) Epidemiological studies to address the frequency and natural history of the conditions and the differences among racial and ethnic groups with respect to the conditions.

(C) The development of improved screening and diagnostic techniques.

(D) Clinical research for the development and evaluation of new treatments.

(E) Information and education programs for health professionals and the public, which may include a coordinated national campaign that—

(i) is designed to increase the awareness and knowledge of postpartum conditions;

(ii) may include public service announcements through television, radio, and other means; and

(iii) may focus on—

(I) raising awareness about screening;

(II) educating new mothers and their families about postpartum conditions to promote earlier diagnosis and treatment; and

(III) ensuring that such education includes complete information concerning postpartum conditions, including its symptoms, methods of coping with the illness, and treatment resources.

(b) REPORT BY THE SECRETARY.—

(1) STUDY.—The Secretary shall conduct a study on the benefits of screening for postpartum conditions.

(2) REPORT.—Not later than 2 years after the date of the enactment of this Act, the Secretary shall complete the study required by paragraph (1) and submit a report to the Congress on the results of such study.

(c) SENSE OF CONGRESS REGARDING LONGITUDINAL STUDY OF RELATIVE MENTAL HEALTH CONSEQUENCES FOR WOMEN OF RESOLVING A PREGNANCY.—

(1) SENSE OF CONGRESS.—It is the sense of the Congress that the Director of the National Institute of Mental Health may conduct a nationally representative longitudinal study (during the period of fiscal years 2011 through 2020) on the relative mental health consequences for women of resolving a

pregnancy (intended and unintended) in various ways, including carrying the pregnancy to term and parenting the child, carrying the pregnancy to term and placing the child for adoption, miscarriage, and having an abortion. This study may assess the incidence, timing, magnitude, and duration of the immediate and long-term mental health consequences (positive or negative) of these pregnancy outcomes.

(2) REPORT.—Beginning not later than 3 years after the date of the enactment of this Act, and periodically thereafter for the duration of the study, such Director may prepare and submit to the Congress reports on the findings of the study.

(d) DEFINITIONS.—In this section:

(1) The term ''postpartum condition'' means postpartum depression or postpartum psychosis.

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

(e) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, in addition to any other amounts authorized to be appropriated for such purpose, there are authorized to be appropriated such sums as may be necessary for each of fiscal years 2011 through 2013.

SEC. 2530. GRANTS TO PROMOTE POSITIVE HEALTH BEHAVIORS AND OUTCOMES.

Part P of title III (42 U.S.C. 280g et seq.) is amended by adding at the end the following:

"SEC. 399V. GRANTS TO PROMOTE POSITIVE HEALTH BEHAVIORS AND OUTCOMES.

''(a) GRANTS AUTHORIZED.—The Secretary, in collaboration with the Director of the Centers for Disease Control and Prevention and other Federal officials determined appropriate by the Secretary, is authorized to award grants to eligible entities to promote positive health behaviors for populations in medically underserved communities through the use of community health workers.

''(b) USE OF FUNDS.—Grants awarded under subsection (a) shall be used to support community health workers—

''(1) to educate, guide, and provide outreach in a community setting regarding health problems prevalent in medically underserved communities, especially racial and ethnic minority populations;

''(2) to educate, guide, and provide experiential learning opportunities that target behavioral risk factors including—

''(A) poor nutrition;

''(B) physical inactivity;

''(C) being overweight or obese;

''(D) tobacco use;

''(E) alcohol and substance use;

''(F) injury and violence;

''(G) risky sexual behavior;

''(H) untreated mental health problems;

''(I) untreated dental and oral health problems; and

''(J) understanding informed consent;

''(3) to educate and provide guidance regarding effective strategies to promote positive health behaviors within the family;

''(4) to educate and provide outreach regarding enrollment in health insurance including the State Children's Health Insurance Program under title XXI of the Social Security Act, Medicare under title XVIII of such Act, and Medicaid under title XIX of such Act;

''(5) to educate and refer underserved populations to appropriate health care agencies and community-based programs and organizations in order to increase access to quality health care services, including preventive health services, and to eliminate duplicative care; or

''(6) to educate, guide, and provide home visitation services regarding maternal health and prenatal care.

''(c) APPLICATION.—

''(1) IN GENERAL.—Each eligible entity that desires to receive a grant under subsection (a) shall submit an application to the Secretary, at such time, in such manner, and accompanied by such information as the Secretary may require.

''(2) CONTENTS.—Each application submitted pursuant to paragraph (1) shall—

''(A) describe the activities for which assistance is sought under this section;

''(B) contain an assurance that, with respect to each community health worker program receiving funds under the grant, such program will provide training and supervision to community health workers to enable such workers to provide authorized program services;

''(C) contain an assurance that the applicant will evaluate the effectiveness of community health worker programs receiving funds under the grant;

''(D) contain an assurance that each community health worker program receiving funds

under the grant will provide services in the cultural context most appropriate for the individuals served by the program;

''(E) contain a plan to document and disseminate project descriptions and results to other States and organizations as identified by the Secretary; and

''(F) describe plans to enhance the capacity of individuals to utilize health services and health-related social services under Federal, State, and local programs by—

''(i) assisting individuals in establishing eligibility under the programs and in receiving the services or other benefits of the programs; and

''(ii) providing other services as the Secretary determines to be appropriate, that may include transportation and translation services.

''(d) PRIORITY.—In awarding grants under subsection (a), the Secretary shall give priority to applicants that—

''(1) propose to target geographic areas—

''(A) with a high percentage of residents who are eligible for health insurance but are uninsured or underinsured;

''(B) with a high percentage of residents who suffer from chronic diseases including pulmonary conditions, hypertension, heart disease, mental disorders, diabetes, and asthma; and

''(C) with a high infant mortality rate;

''(2) have experience in providing health or health-related social services to individuals who are underserved with respect to such services; and

''(3) have documented community activity and experience with community health workers.

''(e) COLLABORATION WITH ACADEMIC INSTITUTIONS.—The Secretary shall encourage community health worker programs receiving funds under this section to collaborate with academic institutions, especially those that graduate a disproportionate number of health and health care students from underrepresented racial and ethnic minority backgrounds. Nothing in this section shall be construed to require such collaboration.

''(f) EVIDENCE-BASED INTERVENTIONS.—The Secretary shall encourage community health worker programs receiving funding under this section to implement an outcome-based payment system that rewards community

health workers for connecting underserved populations with the most appropriate services at the most appropriate time. Nothing in this section shall be construed to require such payment.

''(g) QUALITY ASSURANCE AND COST EFFECTIVENESS.—The Secretary shall establish guidelines for assuring the quality of the training and supervision of community health workers under the programs funded under this section and for assuring the cost-effectiveness of such programs.

''(h) MONITORING.—The Secretary shall monitor community health worker programs identified in approved applications under this section and shall determine whether such programs are in compliance with the guidelines established under subsection (g).

''(i) TECHNICAL ASSISTANCE.—The Secretary may provide technical assistance to community health worker programs identified in approved applications under this section with respect to planning, developing, and operating programs under the grant.

''(j) REPORT TO CONGRESS.—

''(1) IN GENERAL.—Not later than 4 years after the date on which the Secretary first awards grants under subsection (a), the Secretary shall sub-

mit to Congress a report regarding the grant project.

''(2) CONTENTS.—The report required under paragraph (1) shall include the following:

''(A) A description of the programs for which grant funds were used.

''(B) The number of individuals served under such programs.

''(C) An evaluation of—

''(i) the effectiveness of such programs;

''(ii) the cost of such programs; and

''(iii) the impact of the programs on the health outcomes of the community residents.

''(D) Recommendations for sustaining the community health worker programs developed or assisted under this section.

''(E) Recommendations regarding training to enhance career opportunities for community health workers.

''(k) DEFINITIONS.—In this section:

''(1) COMMUNITY HEALTH WORKER.—The term 'community health worker' means an individual who

promotes health or nutrition within the community in which the individual resides—

"(A) by serving as a liaison between communities and health care agencies;

"(B) by providing guidance and social assistance to community residents;

"(C) by enhancing community residents' ability to effectively communicate with health care providers;

"(D) by providing culturally and linguistically appropriate health or nutrition education;

"(E) by advocating for individual and community health, including oral and mental, or nutrition needs; and

"(F) by providing referral and followup services or otherwise coordinating care.

"(2) COMMUNITY SETTING.—The term 'community setting' means a home or a community organization located in the neighborhood in which a participant resides.

"(3) MEDICALLY UNDERSERVED COMMUNITY.—The term 'medically underserved community' means a community identified by a State, United States

territory or possession, or federally recognized Indian tribe—

''(A) that has a substantial number of individuals who are members of a medically underserved population, as defined by section 330(b)(3); and

''(B) a significant portion of which is a health professional shortage area as designated under section 332.

''(4) SUPPORT.—The term 'support' means the provision of training, supervision, and materials needed to effectively deliver the services described in subsection (b), reimbursement for services, and other benefits.

''(5) ELIGIBLE ENTITY.—The term 'eligible entity' means a public or private nonprofit entity (including a State or public subdivision of a State, a public health department, or a federally qualified health center), or a consortium of any of such entities, located in the United States or territory thereof.

''(l) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section $30,000,000 for each of fiscal years 2011 through 2015.''.

SEC. 2531. MEDICAL LIABILITY ALTERNATIVES.

(a) INCENTIVE PAYMENTS FOR MEDICAL LIABILITY REFORM.—

(1) IN GENERAL.—To the extent and in the amounts made available in advance in appropriations Acts, the Secretary shall make an incentive payment, in an amount determined by the Secretary, to each State that has an alternative medical liability law in compliance with this section.

(2) DETERMINATION BY SECRETARY.—The Secretary shall determine that a State has an alternative medical liability law in compliance with this section if the Secretary is satisfied that—

(A) the State enacted the law after the date of the enactment of this Act and is implementing the law;

(B) the law is effective; and

(C) the contents of the law are in accordance with paragraph (4).

(3) CONSIDERATIONS FOR DETERMINING EFFECTIVENESS.—In determining whether an alternative medical liability law is effective under paragraph (2)(B), the Secretary shall consider whether the law—

(A) makes the medical liability system more reliable through prevention of, or prompt and fair resolution of, disputes;

(B) encourages the disclosure of health care errors; and

(C) maintains access to affordable liability insurance.

(4) CONTENTS OF ALTERNATIVE MEDICAL LIABILITY LAW.—The contents of an alternative liability law are in accordance with this paragraph if—

(A) the litigation alternatives contained in the law consist of certificate of merit, early offer, or both; and

(B) the law does not limit attorneys' fees or impose caps on damages.

(b) USE OF INCENTIVE PAYMENTS.—Amounts received by a State as an incentive payment under this section shall be used to improve health care in that State.

(c) TECHNICAL ASSISTANCE.—The Secretary may provide technical assistance to the States applying for or receiving an incentive payment under this section.

(d) REPORTS.—Beginning not later than one year after the date of the enactment of this Act, the Secretary shall submit to the Congress an annual report on the progress States have made in enacting and implementing

alternative medical liability laws in compliance with this section. Such reports shall contain sufficient documentation regarding the effectiveness of such laws to enable an objective comparative analysis of such laws.

(e) DEFINITION.—In this section—

(1) the term ''Secretary'' means the Secretary of Health and Human Services; and

(2) the term ''State'' includes the several States, District of Columbia, the Commonwealth of Puerto Rico, and each other territory or possession of the United States.

(f) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section such sums as may be necessary, to remain available until expended.

SEC. 2532. INFANT MORTALITY PILOT PROGRAMS.

(a) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary''), acting through the Director, shall award grants to eligible entities to create, implement, and oversee infant mortality pilot programs.

(b) PERIOD OF A GRANT.—The period of a grant under this section shall be 5 consecutive fiscal years.

(c) PREFERENCE.—In awarding grants under this section, the Secretary shall give preference to eligible enti-

ties proposing to serve any of the 15 counties or groups of counties with the highest rates of infant mortality in the United States in the past 3 years.

(d) USE OF FUNDS.—Any infant mortality pilot program funded under this section may—

(1) include the development of a plan that identifies the individual needs of each community to be served and strategies to address those needs;

(2) provide outreach to at-risk mothers through programs deemed appropriate by the Director;

(3) develop and implement standardized systems for improved access, utilization, and quality of social, educational, and clinical services to promote healthy pregnancies, full term births, and healthy infancies delivered to women and their infants, such as—

(A) counseling on infant care, feeding, and parenting;

(B) postpartum care;

(C) prevention of premature delivery; and

(D) additional counseling for at-risk mothers, including smoking cessation programs, drug treatment programs, alcohol treatment programs, nutrition and physical activity programs, postpartum depression and domestic vio-

lence programs, social and psychological services, dental care, and parenting programs;

(4) establish a rural outreach program to provide care to at-risk mothers in rural areas;

(5) establish a regional public education campaign, including a campaign to—

(A) prevent preterm births; and

(B) educate the public about infant mortality; and

(6) provide for any other activities, programs, or strategies as identified by the community plan.

(e) LIMITATION.—Of the funds received through a grant under this section for a fiscal year, an eligible entity shall not use more than 10 percent for program evaluation.

(f) REPORTS ON PILOT PROGRAMS.—

(1) IN GENERAL.—Not later than 1 year after receiving a grant, and annually thereafter for the duration of the grant period, each entity that receives a grant under subsection (a) shall submit a report to the Secretary detailing its infant mortality pilot program.

(2) CONTENTS OF REPORT.—The reports required under paragraph (1) shall include information such as the methodology of, and outcomes and

statistics from, the grantee's infant mortality pilot program.

(3) EVALUATION.—The Secretary shall use the reports required under paragraph (1) to evaluate, and conduct statistical research on, infant mortality pilot programs funded through this section.

(g) DEFINITIONS.—For the purposes of this section:

(1) DIRECTOR.—The term ''Director'' means the Director of the Centers for Disease Control and Prevention.

(2) ELIGIBLE ENTITY.—The term ''eligible entity'' means a State, county, city, territorial, or tribal health department that has submitted a proposal to the Secretary that the Secretary deems likely to reduce infant mortality rates within the standard metropolitan statistical area involved.

(3) TRIBAL.—The term ''tribal'' refers to an Indian tribe, a Tribal organization, or an Urban Indian organization, as such terms are defined in section 4 of the Indian Health Care Improvement Act.

(h) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there are authorized to be appropriated $10,000,000 for each of fiscal years 2011 through 2015.

SEC. 2533. SECONDARY SCHOOL HEALTH SCIENCES TRAINING PROGRAM.

(a) PROGRAM.—The Secretary of Health and Human Services, acting through the Administrator of the Health Resources and Services Administration, and in consultation with the Secretary of Education, may establish a health sciences training program consisting of awarding grants and contracts under subsection (b) to prepare secondary school students for careers in health professions.

(b) DEVELOPMENT AND IMPLEMENTATION OF HEALTH SCIENCES CURRICULA.—The Secretary may make grants to, or enter into contracts with, eligible entities—

(1) to plan, develop, or implement secondary school health sciences curricula, including curricula in biology, chemistry, physiology, mathematics, nutrition, and other courses deemed appropriate by the Secretary to prepare students for associate's or bachelor's degree programs in health professions or bachelor's degree programs in health professions-related majors; and

(2) to increase the interest of secondary school students in applying to, and enrolling in, accredited associate's or bachelor's degree programs in health professions or bachelor's degree programs in health professions-related majors, including through—

(A) work-study programs;

(B) programs to increase awareness of careers in health professions; and

(C) other activities to increase such interest.

(c) ELIGIBILITY.—To be eligible for a grant or contract under subsection (b), an entity shall—

(1) be a local educational agency; and

(2) provide assurances that activities under the grant or contract will be carried out in partnership with an accredited health professions school or program, public or private nonprofit hospital, or public or private nonprofit entity.

(d) PREFERENCE.—In awarding grants and contracts under subsection (b), the Secretary shall give preference to entities that have a demonstrated record of at least one of the following:

(1) Graduating a high or significantly improved percentage of students who have exhibited mastery in secondary school State science standards.

(2) Graduating students from disadvantaged backgrounds, including racial and ethnic minorities who are underrepresented in—

(A) associate's or bachelor's degree programs in health professions or bachelor's degree

programs in health professions-related majors; or

(B) health professions.

(e) REPORT.—The Secretary shall submit to the Congress an annual report on the program carried out under this section.

(f) DEFINITIONS.—In this section:

(1) The term ''health profession'' means the profession of any member of the health workforce, as defined in section 764(i) of the Public Health Service Act, as added by section 2261.

(2) The term ''local educational agency'' has the meaning given to the term in section 9101 of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 7801).

(3) The term ''secondary school''—

(A) means a secondary school, as defined in section 9101 of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 7801); and

(B) includes any such school that is a middle school.

(4) The term ''Secretary'' means the Secretary of Health and Human Services except as otherwise specified.

(g) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there are authorized to be appropriated such sums as may be necessary for each of fiscal years 2011 through 2015.

SEC. 2534. COMMUNITY-BASED COLLABORATIVE CARE NETWORKS.

(a) PURPOSE.—The purpose of this subtitle is to establish and provide assistance to community-based collaborative care networks—

(1) to develop or strengthen coordination of services to allow all individuals, including the uninsured and low-income, to receive efficient and higher quality care and to gain entry into and receive services from a comprehensive system of care;

(2) to develop efficient and sustainable infrastructure for a health care delivery system characterized by effective collaboration, information sharing, and clinical and financial coordination among providers of care in the community;

(3) to develop or strengthen activities related to providing coordinated care for individuals with chronic conditions; and

(4) to reduce the use of emergency departments, inpatient and other expensive resources of hospitals and other providers.

(b) CREATION OF THE COMMUNITY-BASED COLLABORATIVE CARE NETWORK PROGRAM.—Part D of title III (42 U.S.C. 254b et seq.), as amended, is further amended by inserting after subpart XII the following new subpart:

"Subpart XIII—Community-Based Collaborative Care Network Program

"SEC. 340O. COMMUNITY-BASED COLLABORATIVE CARE NETWORK PROGRAM.

''(a) IN GENERAL.—The Secretary may award grants to eligible entities for the purpose of establishing model projects to accomplish the following goals:

''(1) To reduce unnecessary use of items and services furnished in emergency departments of hospitals (especially to ensure that individuals without health insurance coverage or with inadequate health insurance coverage do not use the services of such department instead of the services of a primary care provider) through methods such as—

''(A) screening individuals who seek emergency department services for possible eligibility under relevant governmental health programs or for subsidies under such programs; and

''(B) providing such individuals referrals for followup care and chronic condition care.

''(2) To manage chronic conditions to reduce their severity, negative health outcomes, and expense.

''(3) To encourage health care providers to coordinate their efforts so that the most vulnerable patient populations seek and obtain primary care.

''(4) To provide more comprehensive and coordinated care to vulnerable low-income individuals and individuals without health insurance coverage or with inadequate coverage.

''(5) To provide mechanisms for improving both quality and efficiency of care for low-income individuals and families, with an emphasis on those most likely to remain uninsured despite the existence of government programs to make health insurance more affordable.

''(6) To increase preventive services, including screening and counseling, to those who would otherwise not receive such screening, in order to improve health status and reduce long-term complications and costs.

''(7) To ensure the availability of community-wide safety net services, including emergency and trauma care.

''(b) ELIGIBILITY AND GRANTEE SELECTION.—

''(1) APPLICATION.—A community-based collaborative care network described in subsection (d) shall submit to the Secretary an application in such form and manner and containing such information as specified by the Secretary. Such information shall at least—

''(A) identify the health care providers participating in the community-based collaborative care network proposed by the applicant and, if a provider designated in paragraph (d)(1)(B) is not included, the reason such provider is not so included;

''(B) include a description of how the providers plan to collaborate to provide comprehensive and integrated care for low-income individuals, including uninsured and underinsured individuals;

''(C) include a description of the organizational and joint governance structure of the community-based collaborative care network in a manner so that it is clear how decisions will be made, and how the decisionmaking process of the network will include appropriate representation of the participating entities;

''(D) define the geographic areas and populations that the network intends to serve;

''(E) define the scope of services that the network intends to provide and identify any reasons why such services would not include a suggested core service identified by the Secretary under paragraph (3);

''(F) demonstrate the network's ability to meet the requirements of this section; and

''(G) provide assurances that grant funds received shall be used to support the entire community-based collaborative care network.

''(2) SELECTION OF GRANTEES.—

''(A) IN GENERAL.—The Secretary shall select community-based collaborative care networks to receive grants from applications submitted under paragraph (1) on the basis of quality of the proposal involved, geographic diversity (including different States and regions served and urban and rural diversity), and the number of low-income and uninsured individuals that the proposal intends to serve.

''(B) PRIORITY.—The Secretary shall give priority to proposals from community-based collaborative care networks that—

''(i) include the capability to provide the broadest range of services to low-income individuals; and

''(ii) include providers that currently serve a high volume of low-income individuals.

''(C) RENEWAL.—In subsequent years, based on the performance of grantees, the Secretary may provide renewal grants to prior year grant recipients.

''(3) SUGGESTED CORE SERVICES.—For purposes of paragraph (1)(E), the Secretary shall develop a list of suggested core patient and core network services to be provided by a community-based collaborative care network. The Secretary may select a community-based collaborative care network under paragraph (2), the application of which does not include all such services, if such application provides a reasonable explanation why such services are not proposed to be included, and the Secretary determines that the application is otherwise high quality.

''(4) TERMINATION AUTHORITY.—The Secretary may terminate selection of a community-based collaborative care network under this section

for good cause. Such good cause shall include a determination that the network—

''(A) has failed to provide a comprehensive range of coordinated and integrated health care services as required under subsection (d)(2);

''(B) has failed to meet reasonable quality standards;

''(C) has misappropriated funds provided under this section; or

''(D) has failed to make progress toward accomplishing goals set out in subsection (a).

''(c) USE OF FUNDS.—

''(1) USE BY GRANTEES.—Grant funds are provided to community-based collaborative care networks to carry out the following activities:

''(A) Assist low-income individuals without adequate health care coverage to—

''(i) access and appropriately use health services;

''(ii) enroll in applicable public or private health insurance programs;

''(iii) obtain referrals to and see a primary care provider in case such an individual does not have a primary care provider; and

''(iv) obtain appropriate care for chronic conditions.

''(B) Improve heath care by providing case management, application assistance, and appropriate referrals such as through methods to—

''(i) create and meaningfully use a health information technology network to track patients across collaborative providers;

''(ii) perform health outreach, such as by using neighborhood health workers who may inform individuals about the availability of safety net and primary care providers available through the community-based collaborative care network;

''(iii) provide for followup outreach to remind patients of appointments or follow-up care instructions;

''(iv) provide transportation to individuals to and from the site of care;

''(v) expand the capacity to provide care at any provider participating in the community-based collaborative care network, including telehealth, hiring new clinical or administrative staff, providing ac-

cess to services after-hours, on weekends, or otherwise providing an urgent care alternative to an emergency department; and

''(vi) provide a primary care provider or medical home for each network patient.

''(C) Provide direct patient care services as described in their application and approved by the Secretary.

''(2) GRANT FUNDS TO HRSA GRANTEES.—The Secretary may limit the percent of grant funding that may be spent on direct care services provided by grantees of programs administered by the Health Resources and Services Administration (in this section referred to as 'HRSA') or impose other requirements on HRSA grantees participating in a community-based collaborative care network as may be necessary for consistency with the requirements of such programs.

''(3) RESERVATION OF FUNDS FOR NATIONAL PROGRAM PURPOSES.—The Secretary may use not more than 7 percent of funds appropriated to carry out this section for providing technical assistance to grantees, obtaining assistance of experts and consultants, holding meetings, developing of tools, disseminating of information, and evaluation.

''(d) COMMUNITY-BASED COLLABORATIVE CARE NETWORKS.—

''(1) IN GENERAL.—

''(A) DESCRIPTION.—A community-based collaborative care network described in this subsection is a consortium of health care providers with a joint governance structure that provides a comprehensive range of coordinated and integrated health care services for low-income patient populations or medically underserved communities (whether or not such individuals receive benefits under title XVIII, XIX, or XXI of the Social Security Act, private or other health insurance or are uninsured or underinsured) and that complies with any applicable minimum eligibility requirements that the Secretary may determine appropriate.

''(B) REQUIRED INCLUSION.—Each such network shall include the following providers that serve the community (unless such provider does not exist within the community, declines or refuses to participate, or places unreasonable conditions on their participation)—

''(i) A safety net hospital that provides services to a high volume of low-in-

come patients, as demonstrated by meeting the criteria in section 1923(b)(1) of the Social Security Act, or other similar criteria determined by the Secretary; and

''(ii) All Federally qualified health centers (as defined in section 1861(aa) of the Social Security Act (42 U.S.C. 1395x(aa))) located in the geographic area served by the Coordinated Care Network;

''(C) ADDITIONAL INCLUSIONS.—Each such network may include any of the following additional providers:

''(i) A hospital, including a critical access hospital (as defined in section 1820(c)(2) of the Social Security Act (42 U.S.C. 1395i–4(c)(2))).

''(ii) A county or municipal department of health.

''(iii) A rural health clinic or a rural health network (as defined in sections 1861(aa) and 1820(d) of the Social Security Act, respectively (42 U.S.C. 1395x(aa), 1395i–4(d))).

''(iv) A community clinic, including a mental health clinic, substance abuse clinic, or a reproductive health clinic.

''(v) A health center controlled network as defined by section 330(e)(1)(C) of the Public Health Service Act

''(vi) A private practice physician or group practice.

''(vii) A nurse or physician assistant or group practice.

''(viii) An adult day care center.

''(ix) A home health provider.

''(x) Any other type of provider specified by the Secretary, which has a desire to serve low-income and uninsured patients.

''(D) CONSTRUCTION.—

''(i) Nothing in this section shall prohibit a single entity from qualifying as community-based collaborative care network so long as such single entity meets the criteria of a community-based collaborative care network. If the network does not include the providers referenced in clauses (i) and (ii) of subparagraph (B) of this paragraph, the application must ex-

plain the reason pursuant to subsection (b)(1)(A).

''(ii) Participation in a community-based collaborative care network shall not affect Federally qualified health centers' obligation to comply with the governance requirements under section 330 of the Public Health Service Act (42 U.S.C. 254b).

''(iii) Federally qualified health centers participating in a community-based collaborative care network may not be required to provide services beyond their Federal Health Center scope of project approved by HRSA.

''(iv) Nothing in this section shall be construed to expand medical malpractice liability protection under the Federal Tort Claims Act for Section 330-funded Federally qualified health centers.

''(2) COMPREHENSIVE RANGE OF COORDINATED AND INTEGRATED HEALTH CARE SERVICES.—The Secretary shall define criteria for evaluating whether the services offered by a community-based collaborative care network qualify as a comprehensive range

of coordinated and integrated health care services. Such criteria may vary based on the needs of the geographic areas and populations to be served by the network and may include the following:

''(A) Requiring community-based collaborative care networks to include at least the suggested core services identified under subsection (b)(3), or whichever subset of the suggested core services is applicable to a particular network.

''(B) Requiring such networks to assign each patient of the network to a primary care provider responsible for managing that patient's care.

''(C) Requiring the services provided by a community-based collaborative care network to include support services appropriate to meet the health needs of low-income populations in the network's community, which may include chronic care management, nutritional counseling, transportation, language services, enrollment counselors, social services and other services as proposed by the network.

''(D) Providing that the services provided by a community-based collaborative care net-

work may also include long-term care services and other services not specified in this subsection.

''(E) Providing for the approval by the Secretary of a scope of community-based collaborative care network services for each network that addresses an appropriate minimum scope of work consistent with the setting of the network and the health professionals available in the community the network serves.

''(3) CLARIFICATION.—Participation in a community-based collaborative care network shall not disqualify a health care provider from reimbursement under title XVIII, XIX, or XXI of the Social Security Act with respect to services otherwise reimbursable under such title. Nothing in this section shall prevent a community-based collaborative care network that is otherwise eligible to contract with Medicare, a private health insurer, or any other appropriate entity to provide care under Medicare, under health insurance coverage offered by the insurer, or otherwise.

''(e) EVALUATIONS.—

''(1) GRANTEE REPORTS.—Beginning in the third year following an initial grant, each commu-

nity-based collaborative care network shall submit to the Secretary, with respect to each year the grantee has received a grant, an evaluation on the activities carried out by the community-based collaborative care network under the community-based collaborative care network program and shall include—

''(A) the number of people served;

''(B) the most common health problems treated;

''(C) any reductions in emergency department use;

''(D) any improvements in access to primary care;

''(E) an accounting of how amounts received were used, including identification of amounts used for patient care services as may be required for HRSA grantees; and

''(F) to the extent requested by the Secretary, any quality measures or any other measures specified by the Secretary.

''(2) PROGRAM REPORTS.—The Secretary shall submit to Congress an annual evaluation (beginning not later than 6 months after the first reports under paragraph (1) are submitted) on the extent to which emergency department use was reduced as a result

of the activities carried out by the community-based collaborative care network under the program. Each such evaluation shall also include information on—

''(A) the prevalence of certain chronic conditions in various populations, including a comparison of such prevalence in the general population versus in the population of individuals with inadequate health insurance coverage;

''(B) demographic characteristics of the population of uninsured and underinsured individuals served by the community-based collaborative care network involved; and

''(C) the conditions of such individuals for whom services were requested at such emergency departments of participating hospitals.

''(3) AUDIT AUTHORITY.—The Secretary may conduct periodic audits and request periodic spending reports of community-based collaborative care networks under the community-based collaborative care network program.

''(f) CLARIFICATION.—Nothing in this section requires a provider to report individually identifiable information of an individual to government agencies, unless the individual consents, consistent with HIPAA privacy and security law, as defined in section 3009(a)(2).

''(g) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section such sums as may be necessary for each of fiscal years 2011 through 2015.''.

SEC. 2535. COMMUNITY-BASED OVERWEIGHT AND OBESITY PREVENTION PROGRAM.

Part Q of title III (42 U.S.C. 280h et seq.) is amended by inserting after section 399W the following:

''SEC. 399W–1. COMMUNITY-BASED OVERWEIGHT AND OBESITY PREVENTION PROGRAM.

''(a) PROGRAM.—The Secretary shall establish a community-based overweight and obesity prevention program consisting of awarding grants and contracts under subsection (b).

''(b) GRANTS.—The Secretary shall award grants to, or enter into contracts with, eligible entities—

''(1) to plan evidence-based programs for the prevention of overweight and obesity among children and their families through improved nutrition and increased physical activity; or

''(2) to implement such programs.

''(c) ELIGIBILITY.—To be eligible for a grant or contract under subsection (b), an entity shall be a community partnership that demonstrates community support and includes—

''(1) a broad cross section of stakeholders, such as—

''(A) hospitals, health care systems, community health centers, or other health care providers;

''(B) universities, local educational agencies, or childcare providers;

''(C) State, local, and tribal health departments;

''(D) State, local, and tribal park and recreation departments;

''(E) employers; and

''(F) health insurance companies;

''(2) residents of the community; and

''(3) representatives of public and private entities that have a history of working within and serving the community.

''(d) PERIOD OF AWARDS.—

''(1) IN GENERAL.—The period of a grant or contract under this section shall be 5 years, subject to renewal under paragraph (2).

''(2) RENEWAL.—At the end of each fiscal year, the Secretary may renew a grant or contract award under this section only if the grant or contract recipient demonstrates to the Secretary's satisfaction

that the recipient has made appropriate, measurable progress in preventing overweight and obesity.

''(e) REQUIREMENTS.—

''(1) IN GENERAL.—The Secretary may award a grant or contract under this section to an entity only if the entity demonstrates to the Secretary's satisfaction that—

''(A) not later than 90 days after receiving the grant or contract, the entity will establish a steering committee to provide input on the assessment of, and recommendations on improvements to, the entity's program funded through the grant or contract; and

''(B) the entity has conducted or will conduct an assessment of the overweight and obesity problem in its community, including the extent of the problem and factors contributing to the problem.

''(2) MATCHING REQUIREMENT.—The Secretary may award a grant or contract to an eligible entity under this section only if the entity agrees to provide, from non-Federal sources, an amount equal to $1 (in cash or in kind) for each $9 provided through the grant or contract to carry out the activities supported by the grant or contract.

''(3) PAYOR OF LAST RESORT.—The Secretary may award a grant or contract under this section to an entity only if the entity demonstrates to the satisfaction of the Secretary that funds received through the grant or contract will not be expended for any activity to the extent that payment has been made, or can reasonably be expected to be made—

''(A) under any insurance policy;

''(B) under any Federal or State health benefits program (including titles XIX and XXI of the Social Security Act); or

''(C) by an entity which provides health services on a prepaid basis.

''(4) MAINTENANCE OF EFFORT.—The Secretary may award a grant or contract under this section to an entity only if the entity demonstrates to the satisfaction of the Secretary that—

''(A) funds received through the grant or contract will be expended only to supplement, and not supplant, non-Federal and Federal funds otherwise available to the entity for the activities to be funded through the grant or contract; and

''(B) with respect to such activities, the entity will maintain expenditures of non-Federal

amounts for such activities at a level not less than the lesser of such expenditures maintained by the entity for the fiscal year preceding the fiscal year for which the entity receives the grant or contract.

''(f) PREFERENCES.—In awarding grants and contracts under this section, the Secretary shall give preference to eligible entities that—

''(1) will serve communities with high levels of overweight and obesity and related chronic diseases; or

''(2) will plan or implement activities for the prevention of overweight and obesity in school or workplace settings.

''(g) REPORT.—The Secretary shall submit to the Congress an annual report on the program of grants and contracts awarded under this section.

''(h) DEFINITIONS.—In this section:

''(1) The term 'evidence-based' means that methodologically sound research has demonstrated a beneficial health effect in the judgment of the Secretary and includes the Ways to Enhance Children's Activity and Nutrition (We Can) program and curriculum of the National Institutes of Health.

''(2) The term 'local educational agency' has the meaning given to the term in section 9101 of the Elementary and Secondary Education Act of 1965.

''(i) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there are authorized to be appropriated $10,000,000 for fiscal year 2011 and such sums as may be necessary for each of fiscal years 2012 through 2015.''.

SEC. 2536. REDUCING STUDENT-TO-SCHOOL NURSE RATIOS.

(a) DEMONSTRATION GRANTS.—

(1) IN GENERAL.—The Secretary of Education, in consultation with the Secretary of Health and Human Services and the Director of the Centers for Disease Control and Prevention, may make demonstration grants to eligible local educational agencies for the purpose of reducing the student-to-school nurse ratio in public elementary and secondary schools.

(2) SPECIAL CONSIDERATION.—In awarding grants under this section, the Secretary of Education shall give special consideration to applications submitted by high-need local educational agencies that demonstrate the greatest need for new or additional nursing services among children in the public elementary and secondary schools served by the

agency, in part by providing information on current ratios of students to school nurses.

(3) MATCHING FUNDS.—The Secretary of Education may require recipients of grants under this subsection to provide matching funds from non-Federal sources, and shall permit the recipients to match funds in whole or in part with in-kind contributions.

(b) REPORT.—Not later than 24 months after the date on which assistance is first made available to local educational agencies under this section, the Secretary of Education shall submit to the Congress a report on the results of the demonstration grant program carried out under this section, including an evaluation of the effectiveness of the program in improving the student-to-school nurse ratios described in subsection (a) and an evaluation of the impact of any resulting enhanced health of students on learning.

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

(1) The terms ''elementary school'', ''local educational agency'', and ''secondary school'' have the meanings given to those terms in section 9101 of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 7801).

(2) The term ''eligible local educational agency'' means a local educational agency in which the student-to-school nurse ratio in the public elementary and secondary schools served by the agency is 750 or more students to every school nurse.

(3) The term ''high-need local educational agency'' means a local educational agency—

(A) that serves not fewer than 10,000 children from families with incomes below the poverty line; or

(B) for which not less than 20 percent of the children served by the agency are from families with incomes below the poverty line.

(4) The term ''nurse'' means a licensed nurse, as defined under State law.

(d) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there are authorized to be appropriated such sums as may be necessary for each of fiscal years 2011 through 2015.

SEC. 2537. MEDICAL-LEGAL PARTNERSHIPS.

(a) IN GENERAL.—The Secretary shall establish a nationwide demonstration project consisting of—

(1) awarding grants to, and entering into contracts with, medical-legal partnerships to assist pa-

tients and their families to navigate health-related programs and activities; and

(2) evaluating the effectiveness of such partnerships.

(b) USE OF FUNDS.—Amounts received as a grant or contract under this section shall be used to assist patients and their families to navigate health care-related programs and activities and thereby achieve one or more of the following goals:

(1) Enhancing access to health care services.

(2) Improving health outcomes for low-income individuals.

(3) Reducing health disparities.

(4) Enhancing wellness and prevention of chronic conditions.

(c) PROHIBITION.—No funds under this section may be used—

(1) for any medical malpractice or other civil action or proceeding; or

(2) to assist individuals who are not lawfully present in the United States.

(d) REPORT.—Not later than 5 years after the date of the enactment of this Act, the Secretary shall submit a report to the Congress on the results of the demonstra-

tion project under this section. Such report shall include the following:

(1) A description of the extent to which medical-legal partnerships funded through this section achieved the goals described in subsection (b).

(2) Recommendations on the possibility of extending or expanding the demonstration project.

(e) DEFINITIONS.—In this section:

(1) The term ''health disparities'' has the meaning given to the term in section 3171 of the Public Health Service Act, as added by section 2301.

(2) The term ''medical-legal partnership'' means an entity—

(A) that is a collaboration between—

(i) a community health center, public hospital, children's hospital, or other provider of health care services to a significant number of low-income beneficiaries; and

(ii) one or more attorneys; and

(B) whose primary mission is to assist patients and their families navigate health care-related programs and activities.

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

(f) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there are authorized to be appropriated such sums as may be necessary for each of fiscal years 2011 through 2015.

PART 3—EMERGENCY CARE-RELATED PROGRAMS

SEC. 2551. TRAUMA CARE CENTERS.

(a) GRANTS FOR TRAUMA CARE CENTERS.—Section 1241 (42 U.S.C. 300d–41) is amended to read as follows:

''SEC. 1241. GRANTS FOR CERTAIN TRAUMA CENTERS.

''(a) IN GENERAL.—The Secretary shall establish a trauma center program consisting of awarding grants under section (b).

''(b) GRANTS.—The Secretary shall award grants as follows:

''(1) EXISTING CENTERS.—Grants to public, private nonprofit, Indian Health Service, Indian tribal, and urban Indian trauma centers—

''(A) to further the core missions of such centers; or

''(B) to provide emergency relief to ensure the continued and future availability of trauma services by trauma centers—

''(i) at risk of closing or operating in an area where a closing has occurred within their primary service area; or

''(ii) in need of financial assistance following a natural disaster or other catastrophic event, such as a terrorist attack.

''(2) NEW CENTERS.—Grants to local governments and public or private nonprofit entities to establish new trauma centers in urban areas with a substantial degree of trauma resulting from violent crimes.

''(c) MINIMUM QUALIFICATIONS OF TRAUMA CENTERS.—

''(1) PARTICIPATION IN TRAUMA CARE SYSTEM OPERATING UNDER CERTAIN PROFESSIONAL GUIDELINES.—

''(A) LIMITATION.—Subject to subparagraph (B), the Secretary may not award a grant to an existing trauma center under this section unless the center is a participant in a trauma care system that substantially complies with section 1213.

''(B) EXEMPTION.—Subparagraph (A) shall not apply to trauma centers that are lo-

cated in States with no existing trauma care system.

''(2) DESIGNATION.—The Secretary may not award a grant under this section to an existing trauma center unless the center is—

''(A) verified as a trauma center by the American College of Surgeons; or

''(B) designated as a trauma center by the applicable State health or emergency medical services authority.''.

(b) CONSIDERATIONS IN MAKING GRANTS.—Section 1242 (42 U.S.C. 300d–42) is amended to read as follows:

''SEC. 1242. CONSIDERATIONS IN MAKING GRANTS.

''(a) CORE MISSION AWARDS.—

''(1) IN GENERAL.—In awarding grants under section 1241(b)(1)(A), the Secretary shall—

''(A) reserve a minimum of 25 percent of the amount allocated for such grants for level III and level IV trauma centers in rural or underserved areas;

''(B) reserve a minimum of 25 percent of the amount allocated for such grants for level I and level II trauma centers in urban areas; and

''(C) give preference to any application made by a trauma center—

''(i) in a geographic area where growth in demand for trauma services exceeds capacity;

''(ii) that demonstrates the financial support of the State or political subdivision involved;

''(iii) that has at least 1 graduate medical education fellowship in trauma or trauma-related specialties, including neurological surgery, surgical critical care, vascular surgery, and spinal cord injury, for which demand is exceeding supply; or

''(iv) that demonstrates a substantial commitment to serving vulnerable populations.

''(2) FINANCIAL SUPPORT.—For purposes of paragraph (1)(C)(ii), financial support may be demonstrated by State or political subdivision funding for the trauma center's capital or operating expenses (including through State trauma regional advisory coordination activities, Medicaid funding designated for trauma services, or other governmental funding). State funding derived from Federal support shall

not constitute State or local financial support for purposes of preferential treatment under this subsection.

''(3) USE OF FUNDS.—The recipient of a grant under section 1241(b)(1)(A) shall carry out, consistent with furthering the core missions of the center, one or more of the following activities:

''(A) Providing 24-hour-a-day, 7-day-a-week trauma care availability.

''(B) Reducing overcrowding related to throughput of trauma patients.

''(C) Enhancing trauma surge capacity.

''(D) Ensuring physician and essential personnel availability.

''(E) Trauma education and outreach.

''(F) Coordination with local and regional trauma care systems.

''(G) Such other activities as the Secretary may deem appropriate.

''(b) EMERGENCY AWARDS; NEW CENTERS.—In awarding grants under paragraphs (1)(B) and (2) of section 1241(b), the Secretary shall—

''(1) give preference to any application submitted by an applicant that demonstrates the financial support (in accordance with subsection (a)(2))

of the State or political subdivision involved for the activities to be funded through the grant for each fiscal year during which payments are made to the center under the grant; and

''(2) give preference to any application submitted for a trauma center that—

''(A) is providing or will provide trauma care in a geographic area in which the availability of trauma care has either significantly decreased as a result of a trauma center in the area permanently ceasing participation in a system described in section 1241(c)(1) as of a date occurring during the 2-year period preceding the fiscal year for which the trauma center is applying to receive a grant, or in geographic areas where growth in demand for trauma services exceeds capacity;

''(B) will, in providing trauma care during the 1-year period beginning on the date on which the application for the grant is submitted, incur substantial uncompensated care costs in an amount that renders the center unable to continue participation in such system and results in a significant decrease in the

availability of trauma care in the geographic area;

''(C) operates or will operate in rural areas where trauma care availability will significantly decrease if the center is forced to close or downgrade service and substantial costs are contributing to a likelihood of such closure or downgradation;

''(D) is in a geographic location substantially affected by a natural disaster or other catastrophic event such as a terrorist attack; or

''(E) will establish a new trauma service in an urban area with a substantial degree of trauma resulting from violent crimes.

''(c) DESIGNATIONS OF LEVELS OF TRAUMA CENTERS IN CERTAIN STATES.—In the case of a State which has not designated 4 levels of trauma centers, any reference in this section to—

''(1) a level I or level II trauma center is deemed to be a reference to a trauma center within the highest 2 levels of trauma centers designated under State guidelines; and

''(2) a level III or IV trauma center is deemed to be a reference to a trauma center not within such highest 2 levels.''.

(c) CERTAIN AGREEMENTS.—Section 1243 (42 U.S.C. 300d–43) is amended to read as follows:

"SEC. 1243. CERTAIN AGREEMENTS.

"(a) COMMITMENT REGARDING CONTINUED PARTICIPATION IN TRAUMA CARE SYSTEM.—The Secretary may not award a grant to an applicant under section 1241(b) unless the applicant agrees that—

"(1) the trauma center involved will continue participation, or in the case of a new center will participate, in the system described in section 1241(c)(1), except as provided in section 1241(c)(1)(B), throughout the grant period beginning on the date that the center first receives payments under the grant; and

"(2) if the agreement made pursuant to paragraph (1) is violated by the center, the center will be liable to the United States for an amount equal to the sum of—

"(A) the amount of assistance provided to the center under section 1241; and

"(B) an amount representing interest on the amount specified in subparagraph (A).

"(b) MAINTENANCE OF FINANCIAL SUPPORT.—With respect to activities for which funds awarded through a grant under section 1241 are authorized to be expended,

the Secretary may not award such a grant unless the applicant agrees that, during the period in which the trauma center involved is receiving payments under the grant, the center will maintain access to trauma services at levels not less than the levels for the prior year, taking into account—

''(1) reasonable volume fluctuation that is not caused by intentional trauma boundary reduction;

''(2) downgrading of the level of services; and

''(3) whether such center diverts its incoming patients away from such center 5 percent or more of the time during which the center is in operation over the course of the year.

''(c) TRAUMA CARE REGISTRY.—The Secretary may not award a grant to a trauma center under section 1241(b)(1) unless the center agrees that—

''(1) not later than 6 months after the date on which the center submits a grant application to the Secretary, the center will establish and operate a registry of trauma cases in accordance with guidelines developed by the American College of Surgeons; and

''(2) in carrying out paragraph (1), the center will maintain information on the number of trauma cases treated by the center and, for each such case,

the extent to which the center incurs uncompensated costs in providing trauma care.''.

(d) GENERAL PROVISIONS.—Section 1244 (42 U.S.C. 300d–44) is amended to read as follows:

''SEC. 1244. GENERAL PROVISIONS.

''(a) LIMITATION ON DURATION OF SUPPORT.—The period during which a trauma center receives payments under a grant under section 1241(b)(1) shall be for 3 fiscal years, except that the Secretary may waive such requirement for the center and authorize the center to receive such payments for 1 additional fiscal year.

''(b) ELIGIBILITY.—The acquisition of, or eligibility for, a grant under section 1241(b) shall not preclude a trauma center's eligibility for another grant described in such section.

''(c) FUNDING DISTRIBUTION.—Of the total amount appropriated for a fiscal year under section 1245—

''(1) 90 percent shall be used for grants under paragraph (1)(A) of section 1241(b); and

''(2) 10 percent shall be used for grants under paragraphs (1)(B) and (2) of section 1241(b).

''(d) REPORT.—Beginning 2 years after the date of the enactment of the Affordable Health Care for America Act, and every 2 years thereafter, the Secretary shall biennially—

''(1) report to Congress on the status of the grants made pursuant to section 1241;

''(2) evaluate and report to Congress on the overall financial stability of trauma centers in the United States;

''(3) report on the populations using trauma care centers and include aggregate patient data on income, race, ethnicity, and geography; and

''(4) evaluate the effectiveness and efficiency of trauma care center activities using standard public health measures and evaluation methodologies.''.

(e) AUTHORIZATION OF APPROPRIATIONS.—Section 1245 (42 U.S.C. 300d–45) is amended to read as follows:

''SEC. 1245. AUTHORIZATION OF APPROPRIATIONS.

''(a) IN GENERAL.—For the purpose of carrying out this part, there are authorized to be appropriated $100,000,000 for fiscal year 2011, and such sums as may be necessary for each of fiscal years 2012 through 2015. Such authorization of appropriations is in addition to any other authorization of appropriations or amounts that are available for such purpose.

''(b) REALLOCATION.—The Secretary shall reallocate for grants under section 1241(b)(1)(A) any funds appropriated for grants under paragraph (1)(B) or (2) of sec-

tion 1241(b), but not obligated due to insufficient applications eligible for funding.''.

SEC. 2552. EMERGENCY CARE COORDINATION.

(a) IN GENERAL.—Subtitle B of title XXVIII (42 U.S.C. 300hh–10 et seq.) is amended by adding at the end the following:

''SEC. 2816. EMERGENCY CARE COORDINATION.

''(a) EMERGENCY CARE COORDINATION CENTER.—

''(1) ESTABLISHMENT.—The Secretary shall establish, within the Office of the Assistant Secretary for Preparedness and Response, an Emergency Care Coordination Center (in this section referred to as the 'Center'), to be headed by a director.

''(2) DUTIES.—The Secretary, acting through the Director of the Center, in coordination with the Federal Interagency Committee on Emergency Medical Services, shall—

''(A) promote and fund research in emergency medicine and trauma health care;

''(B) promote regional partnerships and more effective emergency medical systems in order to enhance appropriate triage, distribution, and care of routine community patients; and

''(C) promote local, regional, and State emergency medical systems' preparedness for and response to public health events.

''(b) COUNCIL OF EMERGENCY CARE.—

''(1) ESTABLISHMENT.—The Secretary, acting through the Director of the Center, shall establish a Council of Emergency Care to provide advice and recommendations to the Director on carrying out this section.

''(2) COMPOSITION.—The Council shall be comprised of employees of the departments and agencies of the Federal Government who are experts in emergency care and management.

''(c) REPORT.—

''(1) SUBMISSION.—Not later than 12 months after the date of the enactment of the Affordable Health Care for America Act, the Secretary shall submit to the Congress an annual report on the activities carried out under this section.

''(2) CONSIDERATIONS.—In preparing a report under paragraph (1), the Secretary shall consider factors including—

''(A) emergency department crowding and boarding; and

''(B) delays in care following presentation.

''(d) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there are authorized to be appropriated such sums as may be necessary for each of fiscal years 2011 through 2015.''.

(b) FUNCTIONS, PERSONNEL, ASSETS, LIABILITIES, AND ADMINISTRATIVE ACTIONS.—All functions, personnel, assets, and liabilities of, and administrative actions applicable to, the Emergency Care Coordination Center, as in existence on the day before the date of the enactment of this Act, shall be transferred to the Emergency Care Coordination Center established under section 2816(a) of the Public Health Service Act, as added by subsection (a).

SEC. 2553. PILOT PROGRAMS TO IMPROVE EMERGENCY MEDICAL CARE.

Part B of title III (42 U.S.C. 243 et seq.) is amended by inserting after section 314 the following:

''SEC. 315. REGIONALIZED COMMUNICATION SYSTEMS FOR EMERGENCY CARE RESPONSE.

''(a) IN GENERAL.—The Secretary, acting through the Assistant Secretary for Preparedness and Response, shall award not fewer than 4 multiyear contracts or competitive grants to eligible entities to support demonstration programs that design, implement, and evaluate innovative models of regionalized, comprehensive, and accountable emergency care systems.

''(b) ELIGIBLE ENTITY; REGION.—

''(1) ELIGIBLE ENTITY.—In this section, the term 'eligible entity' means a State or a partnership of 1 or more States and 1 or more local governments.

''(2) REGION.—In this section, the term 'region' means an area within a State, an area that lies within multiple States, or a similar area (such as a multicounty area), as determined by the Secretary.

''(c) DEMONSTRATION PROGRAM.—The Secretary shall award a contract or grant under subsection (a) to an eligible entity that proposes a demonstration program to design, implement, and evaluate an emergency medical system that—

''(1) coordinates with public safety services, public health services, emergency medical services, medical facilities, and other entities within a region;

''(2) coordinates an approach to emergency medical system access throughout the region, including 9–1–1 public safety answering points and emergency medical dispatch;

''(3) includes a mechanism, such as a regional medical direction or transport communications system, that operates throughout the region to ensure that the correct patient is taken to the medically ap-

propriate facility (whether an initial facility or a higher level facility) in a timely fashion;

''(4) allows for the tracking of prehospital and hospital resources, including inpatient bed capacity, emergency department capacity, on-call specialist coverage, ambulance diversion status, and the coordination of such tracking with regional communications and hospital destination decisions; and

''(5) includes a consistent regionwide prehospital, hospital, and interfacility data management system that—

''(A) complies with the National EMS Information System, the National Trauma Data Bank, and others;

''(B) reports data to appropriate Federal and State databanks and registries; and

''(C) contains information sufficient to evaluate key elements of prehospital care, hospital destination decisions, including initial hospital and interfacility decisions, and relevant outcomes of hospital care.

''(d) APPLICATION.—

''(1) IN GENERAL.—An eligible entity that seeks a contract or grant described in subsection (a) shall submit to the Secretary an application at such

time and in such manner as the Secretary may require.

''(2) APPLICATION INFORMATION.—Each application shall include—

''(A) an assurance from the eligible entity that the proposed system—

''(i) has been coordinated with the applicable State office of emergency medical services (or equivalent State office);

''(ii) is compatible with the applicable State emergency medical services system;

''(iii) includes consistent indirect and direct medical oversight of prehospital, hospital, and interfacility transport throughout the region;

''(iv) coordinates prehospital treatment and triage, hospital destination, and interfacility transport throughout the region;

''(v) includes a categorization or designation system for special medical facilities throughout the region that is—

''(I) consistent with State laws and regulations; and

''(II) integrated with the protocols for transport and destination throughout the region; and

''(vi) includes a regional medical direction system, a patient tracking system, and a resource allocation system that—

''(I) support day-to-day emergency care system operation;

''(II) can manage surge capacity during a major event or disaster; and

''(III) are integrated with other components of the national and State emergency preparedness system;

''(B) an agreement to make available non-Federal contributions in accordance with subsection (e); and

''(C) such other information as the Secretary may require.

''(e) MATCHING FUNDS.—

''(1) IN GENERAL.—With respect to the costs of the activities to be carried out each year with a contract or grant under subsection (a), a condition for the receipt of the contract or grant is that the eligible entity involved agrees to make available (directly or through donations from public or private entities)

non-Federal contributions toward such costs in an amount that is not less than 25 percent of such costs.

''(2) DETERMINATION OF AMOUNT CONTRIBUTED.—Non-Federal contributions required in paragraph (1) may be in cash or in kind, fairly evaluated, including plant, equipment, or services. Amounts provided by the Federal Government, or services assisted or subsidized to any significant extent by the Federal Government, may not be included in determining the amount of such non-Federal contributions.

''(f) PRIORITY.—The Secretary shall give priority for the award of the contracts or grants described in subsection (a) to any eligible entity that serves a medically underserved population (as defined in section 330(b)(3)).

''(g) REPORT.—Not later than 90 days after the completion of a demonstration program under subsection (a), the recipient of such contract or grant described in such subsection shall submit to the Secretary a report containing the results of an evaluation of the program, including an identification of—

''(1) the impact of the regional, accountable emergency care system on patient outcomes for var-

ious critical care categories, such as trauma, stroke, cardiac emergencies, and pediatric emergencies;

''(2) the system characteristics that contribute to the effectiveness and efficiency of the program (or lack thereof);

''(3) methods of assuring the long-term financial sustainability of the emergency care system;

''(4) the State and local legislation necessary to implement and to maintain the system; and

''(5) the barriers to developing regionalized, accountable emergency care systems, as well as the methods to overcome such barriers.

''(h) EVALUATION.—The Secretary, acting through the Assistant Secretary for Preparedness and Response, shall enter into a contract with an academic institution or other entity to conduct an independent evaluation of the demonstration programs funded under subsection (a), including an evaluation of—

''(1) the performance of the eligible entities receiving the funds; and

''(2) the impact of the demonstration programs.

''(i) DISSEMINATION OF FINDINGS.—The Secretary shall, as appropriate, disseminate to the public and to the appropriate committees of the Congress, the information contained in a report made under subsection (h).

''(j) AUTHORIZATION OF APPROPRIATIONS.—

''(1) IN GENERAL.—There is authorized to be appropriated to carry out this section $12,000,000 for each of fiscal years 2011 through 2015.

''(2) RESERVATION.—Of the amount appropriated to carry out this section for a fiscal year, the Secretary shall reserve 3 percent of such amount to carry out subsection (h) (relating to an independent evaluation).''.

SEC. 2554. ASSISTING VETERANS WITH MILITARY EMERGENCY MEDICAL TRAINING TO BECOME STATE-LICENSED OR CERTIFIED EMERGENCY MEDICAL TECHNICIANS (EMTS).

(a) IN GENERAL.—Part B of title III (42 U.S.C. 243 et seq.), as amended, is amended by inserting after section 315 the following:

''SEC. 315A. ASSISTING VETERANS WITH MILITARY EMERGENCY MEDICAL TRAINING TO BECOME STATE-LICENSED OR CERTIFIED EMERGENCY MEDICAL TECHNICIANS (EMTS).

''(a) PROGRAM.—The Secretary shall establish a program consisting of awarding grants to States to assist veterans who received and completed military emergency medical training while serving in the Armed Forces of the United States to become, upon their discharge or release

from active duty service, State-licensed or certified emergency medical technicians.

''(b) USE OF FUNDS.—Amounts received as a grant under this section may be used to assist veterans described in subsection (a) to become State-licensed or certified emergency medical technicians as follows:

''(1) Providing training.

''(2) Providing reimbursement for costs associated with—

''(A) training; or

''(B) applying for licensure or certification.

''(3) Expediting the licensing or certification process.

''(c) ELIGIBILITY.—To be eligible for a grant under this section, a State shall demonstrate to the Secretary's satisfaction that the State has a shortage of emergency medical technicians.

''(d) REPORT.—The Secretary shall submit to the Congress an annual report on the program under this section.

''(e) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there are authorized to be appropriated such sums as may be necessary for each of fiscal years 2011 through 2015.''.

(b) GAO STUDY AND REPORT.—The Comptroller General of the United States shall—

(1) conduct a study on the barriers experienced by veterans who received training as medical personnel while serving in the Armed Forces of the United States and, upon their discharge or release from active duty service, seek to become licensed or certified in a State as civilian health professionals; and

(2) not later than 2 years after the date of the enactment of this Act, submit to the Congress a report on the results of such study, including recommendations on whether the program established under section 315A of the Public Health Service Act, as added by subsection (a), should be expanded to assist veterans seeking to become licensed or certified in a State as health providers other than emergency medical technicians.

SEC. 2555. DENTAL EMERGENCY RESPONDERS: PUBLIC HEALTH AND MEDICAL RESPONSE.

(a) NATIONAL HEALTH SECURITY STRATEGY.—Section 2802(b)(3) (42 U.S.C. 300hh–1(b)(3)) is amended—

(1) in the matter preceding subparagraph (A), by inserting ''dental and'' before ''mental health facilities''; and

(2) in subparagraph (D), by inserting ''and dental'' after ''medical''.

(b) ALL-HAZARDS PUBLIC HEALTH AND MEDICAL RESPONSE CURRICULA AND TRAINING.—Section 319F(a)(5)(B) (42 U.S.C. 247d–6(a)(5)(B)) is amended by striking ''public health or medical'' and inserting ''public health, medical, or dental''.

SEC. 2556. DENTAL EMERGENCY RESPONDERS: HOMELAND SECURITY.

(a) NATIONAL RESPONSE FRAMEWORK.—Paragraph (6) of section 2 of the Homeland Security Act of 2002 (6 U.S.C. 101) is amended by inserting ''and dental'' after ''emergency medical''.

(b) NATIONAL PREPAREDNESS SYSTEM.—Subparagraph (B) of section 653(b)(4) of the Post-Katrina Emergency Management Reform Act of 2006 (6 U.S.C. 753(b)(4)) is amended by striking ''public health and medical'' and inserting ''public health, medical, and dental''.

(c) CHIEF MEDICAL OFFICER.—Paragraph (5) of section 516(c) of the Homeland Security Act of 2002 (6 U.S.C. 321e(c)) is amended by striking ''medical community'' and inserting ''medical and dental communities''.

PART 4—PAIN CARE AND MANAGEMENT PROGRAMS

SEC. 2561. INSTITUTE OF MEDICINE CONFERENCE ON PAIN.

(a) CONVENING.—Not later than June 30, 2011, the Secretary of Health and Human Services shall seek to enter into an agreement with the Institute of Medicine of the National Academies to convene a Conference on Pain (in this section referred to as ''the Conference'').

(b) PURPOSES.—The purposes of the Conference shall be to—

(1) increase the recognition of pain as a significant public health problem in the United States;

(2) evaluate the adequacy of assessment, diagnosis, treatment, and management of acute and chronic pain in the general population, and in identified racial, ethnic, gender, age, and other demographic groups that may be disproportionately affected by inadequacies in the assessment, diagnosis, treatment, and management of pain;

(3) identify barriers to appropriate pain care, including—

(A) lack of understanding and education among employers, patients, health care providers, regulators, and third-party payors;

(B) barriers to access to care at the primary, specialty, and tertiary care levels, including barriers—

(i) specific to those populations that are disproportionately undertreated for pain;

(ii) related to physician concerns over regulatory and law enforcement policies applicable to some pain therapies; and

(iii) attributable to benefit, coverage, and payment policies in both the public and private sectors; and

(C) gaps in basic and clinical research on the symptoms and causes of pain, and potential assessment methods and new treatments to improve pain care; and

(4) establish an agenda for action in both the public and private sectors that will reduce such barriers and significantly improve the state of pain care research, education, and clinical care in the United States.

(c) OTHER APPROPRIATE ENTITY.—If the Institute of Medicine declines to enter into an agreement under subsection (a), the Secretary of Health and Human Services

may enter into such agreement with another appropriate entity.

(d) REPORT.—A report summarizing the Conference's findings and recommendations shall be submitted to the Congress not later than June 30, 2012.

(e) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there is authorized to be appropriated $500,000 for each of fiscal years 2011 and 2012.

SEC. 2562. PAIN RESEARCH AT NATIONAL INSTITUTES OF HEALTH.

Part B of title IV (42 U.S.C. 284 et seq.) is amended by adding at the end the following:

"SEC. 409J. PAIN RESEARCH.

"(a) RESEARCH INITIATIVES.—

"(1) IN GENERAL.—The Director of NIH is encouraged to continue and expand, through the Pain Consortium, an aggressive program of basic and clinical research on the causes of and potential treatments for pain.

"(2) ANNUAL RECOMMENDATIONS.—Not less than annually, the Pain Consortium, in consultation with the Division of Program Coordination, Planning, and Strategic Initiatives, shall develop and submit to the Director of NIH recommendations on

appropriate pain research initiatives that could be undertaken with funds reserved under section 402A(c)(1) for the Common Fund or otherwise available for such initiatives.

''(3) DEFINITION.—In this subsection, the term 'Pain Consortium' means the Pain Consortium of the National Institutes of Health or a similar trans-National Institutes of Health coordinating entity designated by the Secretary for purposes of this subsection.

''(b) INTERAGENCY PAIN RESEARCH COORDINATING COMMITTEE.—

''(1) ESTABLISHMENT.—The Secretary shall establish not later than 1 year after the date of the enactment of this section and as necessary maintain a committee, to be known as the Interagency Pain Research Coordinating Committee (in this section referred to as the 'Committee'), to coordinate all efforts within the Department of Health and Human Services and other Federal agencies that relate to pain research.

''(2) MEMBERSHIP.—

''(A) IN GENERAL.—The Committee shall be composed of the following voting members:

''(i) Not more than 7 voting Federal representatives as follows:

''(I) The Director of the Centers for Disease Control and Prevention.

''(II) The Director of the National Institutes of Health and the directors of such national research institutes and national centers as the Secretary determines appropriate.

''(III) The heads of such other agencies of the Department of Health and Human Services as the Secretary determines appropriate.

''(IV) Representatives of other Federal agencies that conduct or support pain care research and treatment, including the Department of Defense and the Department of Veterans Affairs.

''(ii) Twelve additional voting members appointed under subparagraph (B).

''(B) ADDITIONAL MEMBERS.—The Committee shall include additional voting members appointed by the Secretary as follows:

''(i) Six members shall be appointed from among scientists, physicians, and other health professionals, who—

''(I) are not officers or employees of the United States;

''(II) represent multiple disciplines, including clinical, basic, and public health sciences;

''(III) represent different geographical regions of the United States; and

''(IV) are from practice settings, academia, manufacturers, or other research settings.

''(ii) Six members shall be appointed from members of the general public, who are representatives of leading research, advocacy, and service organizations for individuals with pain-related conditions.

''(C) NONVOTING MEMBERS.—The Committee shall include such nonvoting members as the Secretary determines to be appropriate.

''(3) CHAIRPERSON.—The voting members of the Committee shall select a chairperson from among such members. The selection of a chairperson

shall be subject to the approval of the Director of NIH.

''(4) MEETINGS.—The Committee shall meet at the call of the chairperson of the Committee or upon the request of the Director of NIH, but in no case less often than once each year.

''(5) DUTIES.—The Committee shall—

''(A) develop a summary of advances in pain care research supported or conducted by the Federal agencies relevant to the diagnosis, prevention, and treatment of pain and diseases and disorders associated with pain;

''(B) identify critical gaps in basic and clinical research on the symptoms and causes of pain;

''(C) make recommendations to ensure that the activities of the National Institutes of Health and other Federal agencies, including the Department of Defense and the Department of Veteran Affairs, are free of unnecessary duplication of effort;

''(D) make recommendations on how best to disseminate information on pain care; and

''(E) make recommendations on how to expand partnerships between public entities, in-

cluding Federal agencies, and private entities to expand collaborative, crosscutting research.

''(6) REVIEW.—The Secretary shall review the necessity of the Committee at least once every 2 years.''.

SEC. 2563. PUBLIC AWARENESS CAMPAIGN ON PAIN MANAGEMENT.

Part B of title II (42 U.S.C. 238 et seq.) is amended by adding at the end the following:

''SEC. 249. NATIONAL EDUCATION OUTREACH AND AWARENESS CAMPAIGN ON PAIN MANAGEMENT.

''(a) ESTABLISHMENT.—Not later than 12 months after the date of the enactment of this section, the Secretary shall establish and implement a national pain care education outreach and awareness campaign described in subsection (b).

''(b) REQUIREMENTS.—The Secretary shall design the public awareness campaign under this section to educate consumers, patients, their families, and other caregivers with respect to—

''(1) the incidence and importance of pain as a national public health problem;

''(2) the adverse physical, psychological, emotional, societal, and financial consequences that can

result if pain is not appropriately assessed, diagnosed, treated, or managed;

''(3) the availability, benefits, and risks of all pain treatment and management options;

''(4) having pain promptly assessed, appropriately diagnosed, treated, and managed, and regularly reassessed with treatment adjusted as needed;

''(5) the role of credentialed pain management specialists and subspecialists, and of comprehensive interdisciplinary centers of treatment expertise;

''(6) the availability in the public, nonprofit, and private sectors of pain management-related information, services, and resources for consumers, employers, third-party payors, patients, their families, and caregivers, including information on—

''(A) appropriate assessment, diagnosis, treatment, and management options for all types of pain and pain-related symptoms; and

''(B) conditions for which no treatment options are yet recognized; and

''(7) other issues the Secretary deems appropriate.

''(c) CONSULTATION.—In designing and implementing the public awareness campaign required by this section, the Secretary shall consult with organizations rep-

resenting patients in pain and other consumers, employers, physicians including physicians specializing in pain care, other pain management professionals, medical device manufacturers, and pharmaceutical companies.

''(d) COORDINATION.—

''(1) LEAD OFFICIAL.—The Secretary shall designate one official in the Department of Health and Human Services to oversee the campaign established under this section.

''(2) AGENCY COORDINATION.—The Secretary shall ensure the involvement in the public awareness campaign under this section of the Surgeon General of the Public Health Service, the Director of the Centers for Disease Control and Prevention, and such other representatives of offices and agencies of the Department of Health and Human Services as the Secretary determines appropriate.

''(e) UNDERSERVED AREAS AND POPULATIONS.—In designing the public awareness campaign under this section, the Secretary shall—

''(1) take into account the special needs of geographic areas and racial, ethnic, gender, age, and other demographic groups that are currently underserved; and

''(2) provide resources that will reduce disparities in access to appropriate diagnosis, assessment, and treatment.

''(f) GRANTS AND CONTRACTS.—The Secretary may make awards of grants, cooperative agreements, and contracts to public agencies and private nonprofit organizations to assist with the development and implementation of the public awareness campaign under this section.

''(g) EVALUATION AND REPORT.—Not later than the end of fiscal year 2012, the Secretary shall prepare and submit to the Congress a report evaluating the effectiveness of the public awareness campaign under this section in educating the general public with respect to the matters described in subsection (b).

''(h) AUTHORIZATION OF APPROPRIATIONS.—For purposes of carrying out this section, there are authorized to be appropriated $2,000,000 for fiscal year 2011 and $4,000,000 for each of fiscal years 2012 and 2015.''.

Subtitle C—Food and Drug Administration

PART 1—IN GENERAL

SEC. 2571. NATIONAL MEDICAL DEVICE REGISTRY.

(a) REGISTRY.—

(1) IN GENERAL.—Section 519 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360i) is amended—

(A) by redesignating subsection (g) as subsection (h); and

(B) by inserting after subsection (f) the following:

''National Medical Device Registry

''(g)(1)(A) The Secretary shall establish a national medical device registry (in this subsection referred to as the 'registry') to facilitate analysis of postmarket safety and outcomes data on each covered device.

''(B) In this subsection, the term 'covered device'—

''(i) shall include each class III device; and

''(ii) may include, as the Secretary determines appropriate and specifies in regulation, a class II device that is life-supporting or life-sustaining.

''(C) Notwithstanding subparagraph (B)(i), the Secretary may by order exempt a class III device from the provisions of this subsection if the Secretary concludes that inclusion of information on the device in the registry will not provide useful information on safety or effectiveness.

''(2) In developing the registry, the Secretary shall, in consultation with the Commissioner of Food and Drugs,

the Administrator of the Centers for Medicare & Medicaid Services, the Administrator of the Agency for Healthcare Research and Quality, the head of the Office of the National Coordinator for Health Information Technology, and the Secretary of Veterans Affairs, determine the best methods for—

''(A) including in the registry, in a manner consistent with subsection (f), appropriate information to identify each covered device by type, model, and serial number or other unique identifier;

''(B) validating methods for analyzing patient safety and outcomes data from multiple sources and for linking such data with the information included in the registry as described in subparagraph (A), including, to the extent feasible, use of—

''(i) data provided to the Secretary under other provisions of this chapter; and

''(ii) information from public and private sources identified under paragraph (3);

''(C) integrating the activities described in this subsection (so as to avoid duplication) with—

''(i) activities under paragraph (3) of section 505(k) (relating to active postmarket risk identification);

''(ii) activities under paragraph (4) of section 505(k) (relating to advanced analysis of drug safety data);

''(iii) other postmarket device surveillance activities of the Secretary authorized by this chapter; and

''(iv) registries carried out by or for the Agency for Healthcare Research and Quality; and

''(D) providing public access to the data and analysis collected or developed through the registry in a manner and form that protects patient privacy and proprietary information and is comprehensive, useful, and not misleading to patients, physicians, and scientists.

''(3)(A) To facilitate analyses of postmarket safety and patient outcomes for covered devices, the Secretary shall, in collaboration with public, academic, and private entities, develop methods to—

''(i) obtain access to disparate sources of patient safety and outcomes data, including—

''(I) Federal health-related electronic data (such as data from the Medicare program under title XVIII of the Social Secu-

rity Act or from the health systems of the Department of Veterans Affairs);

''(II) private sector health-related electronic data (such as pharmaceutical purchase data and health insurance claims data); and

''(III) other data as the Secretary deems necessary to permit postmarket assessment of device safety and effectiveness; and

''(ii) link data obtained under clause (i) with information in the registry.

''(B) In this paragraph, the term 'data' refers to information respecting a covered device, including claims data, patient survey data, standardized analytic files that allow for the pooling and analysis of data from disparate data environments, electronic health records, and any other data deemed appropriate by the Secretary.

''(4) The Secretary shall promulgate regulations for establishment and operation of the registry under paragraph (1). Such regulations—

''(A)(i) in the case of covered devices that are sold on or after the date of the enactment of this subsection, shall require manufacturers of such devices to submit information to the registry, includ-

ing, for each such device, the type, model, and serial number or, if required under subsection (f), other unique device identifier; and

''(ii) in the case of covered devices that are sold before such date, may require manufacturers of such devices to submit such information to the registry, if deemed necessary by the Secretary to protect the public health;

''(B) shall establish procedures—

''(i) to permit linkage of information submitted pursuant to subparagraph (A) with patient safety and outcomes data obtained under paragraph (3); and

''(ii) to permit analyses of linked data;

''(C) may require covered device manufacturers to submit such other information as is necessary to facilitate postmarket assessments of device safety and effectiveness and notification of device risks;

''(D) shall establish requirements for regular and timely reports to the Secretary, which shall be included in the registry, concerning adverse event trends, adverse event patterns, incidence and prevalence of adverse events, and other information the Secretary determines appropriate, which may include

data on comparative safety and outcomes trends; and

''(E) shall establish procedures to permit public access to the information in the registry in a manner and form that protects patient privacy and proprietary information and is comprehensive, useful, and not misleading to patients, physicians, and scientists.

''(5)(A) The Secretary shall promulgate final regulations under paragraph (4) not later than 36 months after the date of the enactment of this subsection.

''(B) Before issuing the notice of proposed rulemaking preceding the final regulations described in subparagraph (A), the Secretary shall hold a public hearing before an advisory committee on the issue of which class II devices to include in the definition of covered devices.

''(C) The Secretary shall include in any regulation under this subsection an explanation demonstrating that the requirements of such regulation—

''(i) do not duplicate other Federal requirements; and

''(ii) do not impose an undue burden on device manufacturers.

''(6) With respect to any entity that submits or is required to submit a safety report or other information

in connection with the safety of a device under this section (and any release by the Secretary of that report or information), such report or information shall not be construed to reflect necessarily a conclusion by the entity or the Secretary that the report or information constitutes an admission that the product involved malfunctioned, caused or contributed to an adverse experience, or otherwise caused or contributed to a death, serious injury, or serious illness. Such an entity need not admit, and may deny, that the report or information submitted by the entity constitutes an admission that the product involved malfunctioned, caused or contributed to an adverse experience, or caused or contributed to a death, serious injury, or serious illness.

''(7) To carry out this subsection, there are authorized to be appropriated such sums as may be necessary for each of fiscal years 2011 and 2012.''.

(2) EFFECTIVE DATE.—The Secretary of Health and Human Services shall establish and begin implementation of the registry under section 519(g) of the Federal Food, Drug, and Cosmetic Act, as added by paragraph (1), by not later than the date that is 36 months after the date of the enactment of this Act, without regard to whether or not final regulations to establish and operate the registry have been promulgated by such date.

(3) CONFORMING AMENDMENT.—Section 303(f)(1)(B)(ii) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 333(f)(1)(B)(ii)) is amended by striking ''519(g)'' and inserting ''519(h)''.

(b) ELECTRONIC EXCHANGE AND USE IN CERTIFIED ELECTRONIC HEALTH RECORDS OF UNIQUE DEVICE IDENTIFIERS.—

(1) RECOMMENDATIONS.—The HIT Policy Committee established under section 3002 of the Public Health Service Act (42 U.S.C. 300jj–12) shall recommend to the head of the Office of the National Coordinator for Health Information Technology standards, implementation specifications, and certification criteria for the electronic exchange and use in certified electronic health records of a unique device identifier for each covered device (as defined under section 519(g)(1)(B) of the Federal Food, Drug, and Cosmetic Act, as added by subsection (a)).

(2) STANDARDS, IMPLEMENTATION CRITERIA, AND CERTIFICATION CRITERIA.—The Secretary of Health and Human Services, acting through the head of the Office of the National Coordinator for Health Information Technology, shall adopt standards, implementation specifications, and certification

criteria for the electronic exchange and use in certified electronic health records of a unique device identifier for each covered device referred to in paragraph (1), if such an identifier is required by section 519(f) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360i(f)) for the device.

(c) UNIQUE DEVICE IDENTIFICATION SYSTEM.—The Secretary of Health and Human Services, acting through the Commissioner of Food and Drugs, shall issue proposed regulations to implement section 519(f) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360i(f)) not later than 6 months after the date of the enactment of this Act.

SEC. 2572. NUTRITION LABELING OF STANDARD MENU ITEMS AT CHAIN RESTAURANTS AND OF ARTICLES OF FOOD SOLD FROM VENDING MACHINES.

(a) TECHNICAL AMENDMENTS.—Section 403(q)(5)(A) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 343(q)(5)(A)) is amended—

(1) in subclause (i), by inserting ''except as provided in clause (H)(ii)(III),'' after ''(i)'' ; and

(2) in subclause (ii), by inserting ''except as provided in clause (H)(ii)(III),'' after ''(ii)''.

(b) LABELING REQUIREMENTS.—Section 403(q)(5) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 343(q)(5)) is amended by adding at the end the following:

''(H) RESTAURANTS, RETAIL FOOD ESTABLISHMENTS, AND VENDING MACHINES.—

''(i) GENERAL REQUIREMENTS FOR RESTAURANTS AND SIMILAR RETAIL FOOD ESTABLISHMENTS.—Except for food described in subclause (vii), in the case of food that is a standard menu item that is offered for sale in a restaurant or similar retail food establishment that is part of a chain with 20 or more locations doing business under the same name (regardless of the type of ownership of the locations) and offering for sale substantially the same menu items, the restaurant or similar retail food establishment shall disclose the information described in subclauses (ii) and (iii).

''(ii) INFORMATION REQUIRED TO BE DISCLOSED BY RESTAURANTS AND RETAIL FOOD ESTABLISHMENTS.—Except as provided in subclause (vii), the restaurant or similar retail food establishment shall disclose in a clear and conspicuous manner—

''(I)(aa) in a nutrient content disclosure statement adjacent to the name of the standard

menu item, so as to be clearly associated with the standard menu item, on the menu listing the item for sale, the number of calories contained in the standard menu item, as usually prepared and offered for sale; and

''(bb) a succinct statement concerning suggested daily caloric intake, as specified by the Secretary by regulation and posted prominently on the menu and designed to enable the public to understand, in the context of a total daily diet, the significance of the caloric information that is provided on the menu;

''(II)(aa) in a nutrient content disclosure statement adjacent to the name of the standard menu item, so as to be clearly associated with the standard menu item, on the menu board, including a drive-through menu board, the number of calories contained in the standard menu item, as usually prepared and offered for sale; and

''(bb) a succinct statement concerning suggested daily caloric intake, as specified by the Secretary by regulation and posted prominently on the menu board, designed to enable the public to understand, in the context of a total daily

diet, the significance of the nutrition information that is provided on the menu board;

''(III) in a written form, available on the premises of the restaurant or similar retail establishment and to the consumer upon request, the nutrition information required under clauses (C) and (D) of subparagraph (1); and

''(IV) on the menu or menu board, a prominent, clear, and conspicuous statement regarding the availability of the information described in item (III).

''(iii) SELF-SERVICE FOOD AND FOOD ON DISPLAY.—Except as provided in subclause (vii), in the case of food sold at a salad bar, buffet line, cafeteria line, or similar self-service facility, and for self-service beverages or food that is on display and that is visible to customers, a restaurant or similar retail food establishment shall place adjacent to each food offered a sign that lists calories per displayed food item or per serving.

''(iv) REASONABLE BASIS.—For the purposes of this clause, a restaurant or similar retail food establishment shall have a reasonable basis for its nutrient content disclosures, including nutrient databases, cookbooks, laboratory analyses, and other reasonable

means, as described in section 101.10 of title 21, Code of Federal Regulations (or any successor regulation) or in a related guidance of the Food and Drug Administration.

''(v) MENU VARIABILITY AND COMBINATION MEALS.—The Secretary shall establish by regulation standards for determining and disclosing the nutrient content for standard menu items that come in different flavors, varieties, or combinations, but which are listed as a single menu item, such as soft drinks, ice cream, pizza, doughnuts, or children's combination meals, through means determined by the Secretary, including ranges, averages, or other methods.

''(vi) ADDITIONAL INFORMATION.—If the Secretary determines that a nutrient, other than a nutrient required under subclause (ii)(III), should be disclosed for the purpose of providing information to assist consumers in maintaining healthy dietary practices, the Secretary may require, by regulation, disclosure of such nutrient in the written form required under subclause (ii)(III).

''(vii) NONAPPLICABILITY TO CERTAIN FOOD.—

''(I) IN GENERAL.—Subclauses (i) through (vi) do not apply to—

''(aa) items that are not listed on a menu or menu board (such as condiments and other items placed on the table or counter for general use);

''(bb) daily specials, temporary menu items appearing on the menu for less than 60 days per calendar year, or custom orders; or

''(cc) such other food that is part of a customary market test appearing on the menu for less than 90 days, under terms and conditions established by the Secretary.

''(II) WRITTEN FORMS.—Clause (C) shall apply to any regulations promulgated under subclauses (ii)(III) and (vi).

''(viii) VENDING MACHINES.—In the case of an article of food sold from a vending machine that—

''(I) does not permit a prospective purchaser to examine the Nutrition Facts Panel before purchasing the article or does not otherwise provide visible nutrition information at the point of purchase; and

''(II) is operated by a person who is engaged in the business of owning or operating 20 or more vending machines,

the vending machine operator shall provide a sign in close proximity to each article of food or the selection button that includes a clear and conspicuous statement disclosing the number of calories contained in the article.

''(ix) VOLUNTARY PROVISION OF NUTRITION INFORMATION.—

''(I) IN GENERAL.—An authorized official of any restaurant or similar retail food establishment or vending machine operator not subject to the requirements of this clause may elect to be subject to the requirements of such clause, by registering biannually the name and address of such restaurant or similar retail food establishment or vending machine operator with the Secretary, as specified by the Secretary by regulation.

''(II) REGISTRATION.—Within 120 days of the enactment of this clause, the Secretary shall publish a notice in the Federal Register specifying the terms and conditions for implementa-

tion of item (I), pending promulgation of regulations.

''(III) RULE OF CONSTRUCTION.—Nothing in this subclause shall be construed to authorize the Secretary to require an application, review, or licensing process for any entity to register with the Secretary, as described in such item.

''(x) REGULATIONS.—

''(I) PROPOSED REGULATION.—Not later than 1 year after the date of the enactment of this clause, the Secretary shall promulgate proposed regulations to carry out this clause.

''(II) CONTENTS.—In promulgating regulations, the Secretary shall—

''(aa) consider standardization of recipes and methods of preparation, reasonable variation in serving size and formulation of menu items, space on menus and menu boards, inadvertent human error, training of food service workers, variations in ingredients, and other factors, as the Secretary determines; and

''(bb) specify the format and manner of the nutrient content disclosure requirements under this subclause.

''(III) REPORTING.—The Secretary shall submit to the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Energy and Commerce of the House of Representatives a quarterly report that describes the Secretary's progress toward promulgating final regulations under this subparagraph.

''(xi) DEFINITION.—In this clause, the term 'menu' or 'menu board' means the primary writing of the restaurant or other similar retail food establishment from which a consumer makes an order selection.''.

(c) NATIONAL UNIFORMITY.—Section 403A(a)(4) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 343–1(a)(4)) is amended by striking ''except a requirement for nutrition labeling of food which is exempt under subclause (i) or (ii) of section 403(q)(5)(A)'' and inserting ''except that this paragraph does not apply to food that is offered for sale in a restaurant or similar retail food establishment that is not part of a chain with 20 or more locations doing business under the same name (regardless of the type of ownership of the locations) and offering for sale substantially the same menu items unless such restaurant or similar retail food establishment complies with

the voluntary provision of nutrition information requirements under section 403(q)(5)(H)(ix)''.

(d) RULE OF CONSTRUCTION.—Nothing in the amendments made by this section shall be construed—

(1) to preempt any provision of State or local law, unless such provision establishes or continues into effect nutrient content disclosures of the type required under section 403(q)(5)(H) of the Federal Food, Drug, and Cosmetic Act (as added by subsection (b)) and is expressly preempted under section 403A(a)(4) of such Act;

(2) to apply to any State or local requirement respecting a statement in the labeling of food that provides for a warning concerning the safety of the food or component of the food; or

(3) except as provided in section 403(q)(5)(H)(ix) of the Federal Food, Drug, and Cosmetic Act (as added by subsection (b)), to apply to any restaurant or similar retail food establishment other than a restaurant or similar retail food establishment described in section 403(q)(5)(H)(i) of such Act.

SEC. 2573. PROTECTING CONSUMER ACCESS TO GENERIC DRUGS.

(a) FINDINGS; PURPOSE.—

(1) FINDINGS.—The Congress finds the following:

(A) In 1984, the Drug Price Competition and Patent Term Restoration Act (Pub. L. 98–417; in this subsection referred to as the ''1984 Act'') was enacted with the intent of facilitating the early entry of generic drugs while preserving incentives for innovation.

(B) Prescription drugs make up 10 percent of national health care spending, but for the past decade have been one of the fastest growing segments of health care expenditures.

(C) Until recently, the 1984 Act was successful in facilitating generic competition to the benefit of consumers and health care payers—although 67 percent of all prescriptions dispensed in the United States are generic drugs, they account for only 20 percent of all expenditures.

(D) In recent years, the intent of the 1984 Act has been subverted by certain settlement agreements between brand companies and their potential generic competitors that make reverse payments, i.e., payments by the brand company to the generic company.

(E) These settlement agreements have unduly delayed the marketing of low-cost generic drugs contrary to free competition and the interests of consumers.

(F) The state of antitrust law relating to such settlement agreements is unsettled.

(2) PURPOSE.—The purpose of this section is to provide an additional means to effectuate the intent of the 1984 Act by enhancing competition in the pharmaceutical market by stopping agreements between brand name and generic drug manufacturers that limit, delay, or otherwise prevent competition from generic drugs.

(b) IN GENERAL.—Section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) is amended by adding at the end the following:

''(w) PROTECTING CONSUMER ACCESS TO GENERIC DRUGS.—

''(1) UNFAIR AND DECEPTIVE ACTS AND PRACTICES RELATED TO NEW DRUG APPLICATIONS.—

''(A) CONDUCT PROHIBITED.—It shall be unlawful for any person to directly or indirectly be a party to any agreement resolving or settling a patent infringement claim in which—

''(i) an ANDA filer receives anything of value; and

''(ii) the ANDA filer agrees to limit or forego research, development, manufacturing, marketing, or sales, for any period of time, of the drug that is to be manufactured under the ANDA involved and is the subject of the patent infringement claim.

''(B) EXCEPTIONS.—Notwithstanding subparagraph (A)(i), subparagraph (A) does not prohibit a resolution or settlement of a patent infringement claim in which the value received by the ANDA filer includes no more than—

''(i) the right to market the drug that is to be manufactured under the ANDA involved and is the subject of the patent infringement claim, before the expiration of—

''(I) the patent that is the basis for the patent infringement claim; or

''(II) any other statutory exclusivity that would prevent the marketing of such drug; and

''(ii) the waiver of a patent infringement claim for damages based on prior marketing of such drug.

''(C) ENFORCEMENT.—

''(i) IN GENERAL.—A violation of subparagraph (A) shall be treated as an unfair and deceptive act or practice and an unfair method of competition in or affecting interstate commerce prohibited under section 5 of the Federal Trade Commission Act and shall be enforced by the Federal Trade Commission in the same manner, by the same means, and with the same jurisdiction as though all applicable terms and provisions of the Federal Trade Commission Act were incorporated into and made a part of this subsection.

''(ii) INAPPLICABILITY.—Subchapter A of chapter VII shall not apply with respect to this subsection.

''(D) DEFINITIONS.—In this subsection:

''(i) AGREEMENT.—The term 'agreement' means anything that would constitute an agreement under section 5 of the Federal Trade Commission Act.

''(ii) AGREEMENT RESOLVING OR SETTLING.—The term 'agreement resolving or settling', in reference to a patent infringement claim, includes any agreement that is contingent upon, provides a contingent condition for, or is otherwise related to the resolution or settlement of the claim.

''(iii) ANDA.—The term 'ANDA' means an abbreviated new drug application for the approval of a new drug under section (j).

''(iv) ANDA FILER.—The term 'ANDA filer' means a party that has filed an ANDA with the Food and Drug Administration.

''(v) PATENT INFRINGEMENT.—The term 'patent infringement' means infringement of any patent or of any filed patent application, extension, reissuance, renewal, division, continuation, continuation in part, reexamination, patent term restoration, patent of addition, or extension thereof.

''(vi) PATENT INFRINGEMENT CLAIM.—The term 'patent infringement claim' means any allegation made to an

ANDA filer, whether or not included in a complaint filed with a court of law, that its ANDA or drug to be manufactured under such ANDA may infringe any patent.

''(2) FTC RULEMAKING.—The Federal Trade Commission may, by rule promulgated under section 553 of title 5, United States Code, exempt certain agreements described in paragraph (1) from the requirements of this subsection if the Commission finds such agreements to be in furtherance of market competition and for the benefit of consumers. Consistent with the authority of the Commission, such rules may include interpretive rules and general statements of policy with respect to the practices prohibited under paragraph (1).''.

(c) NOTICE AND CERTIFICATION OF AGREEMENTS.—

(1) NOTICE OF ALL AGREEMENTS.—Section 1112(c)(2) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (21 U.S.C. 3155 note) is amended by—

(A) striking ''the Commission the'' and inserting the following: ''the Commission—

''(A) the'';

(B) striking the period at the end and inserting ''; and''; and

(C) adding at the end the following:

''(B) any other agreement the parties enter into within 30 days of entering into an agreement covered by subsection (a) or (b).''.

(2) CERTIFICATION OF AGREEMENTS.—Section 1112 of such Act is amended by adding at the end the following:

''(d) CERTIFICATION.—The chief executive officer or the company official responsible for negotiating any agreement required to be filed under subsection (a), (b), or (c) shall execute and file with the Assistant Attorney General and the Commission a certification as follows: 'I declare under penalty of perjury that the following is true and correct: The materials filed with the Federal Trade Commission and the Department of Justice under section 1112 of subtitle B of title XI of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, with respect to the agreement referenced in this certification: (1) represent the complete, final, and exclusive agreement between the parties; (2) include any ancillary agreements that are contingent upon, provide a contingent condition for, or are otherwise related to, the referenced agreement; and (3) include written descriptions of any oral agreements, representations, commitments, or promises between the parties that are responsive to subsection (a) or

(b) of such section 1112 and have not been reduced to writing.'.''.

(d) GAO STUDY.—

(1) STUDY.—Beginning 2 years after the date of enactment of this Act, and each year for a period of 4 years thereafter, the Comptroller General shall conduct a study on the litigation in United States courts during the period beginning 5 years prior to the date of enactment of this Act relating to patent infringement claims involving generic drugs, the number of patent challenges initiated by manufacturers of generic drugs, and the number of settlements of such litigation. The Comptroller General shall transmit to Congress a report of the findings of such a study and an analysis of the effect of the amendments made by subsections (b) and (c) on such litigation, whether such amendments have had an effect on the number and frequency of claims settled, and whether such amendments resulted in earlier or delayed entry of generic drugs to market, including whether any harm or benefit to consumers has resulted.

(2) DISCLOSURE OF AGREEMENTS.—Notwithstanding any other law, agreements filed under section 1112 of the Medicare Prescription Drug, Im-

provement, and Modernization Act of 2003 (21 U.S.C. 355 note), or unaggregated information from such agreements, shall be disclosed to the Comptroller General for purposes of the study under paragraph (1) within 30 days of a request by the Comptroller General.

PART 2—BIOSIMILARS

SEC. 2575. LICENSURE PATHWAY FOR BIOSIMILAR BIOLOGICAL PRODUCTS.

(a) LICENSURE OF BIOLOGICAL PRODUCTS AS BIOSIMILAR OR INTERCHANGEABLE.—Section 351 of the Public Health Service Act (42 U.S.C. 262) is amended—

(1) in subsection (a)(1)(A), by inserting ''under this subsection or subsection (k)'' after ''biologics license''; and

(2) by adding at the end the following:

''(k) LICENSURE OF BIOLOGICAL PRODUCTS AS BIOSIMILAR OR INTERCHANGEABLE.—

''(1) IN GENERAL.—Any person may submit an application for licensure of a biological product under this subsection.

''(2) CONTENT.—

''(A) IN GENERAL.—

''(i) REQUIRED INFORMATION.—An application submitted under this subsection

shall include information demonstrating that—

''(I) the biological product is biosimilar to a reference product based upon data derived from—

''(aa) analytical studies that demonstrate that the biological product is highly similar to the reference product notwithstanding minor differences in clinically inactive components;

''(bb) animal studies (including the assessment of toxicity); and

''(cc) a clinical study or studies (including the assessment of immunogenicity and pharmacokinetics or pharmacodynamics) that are sufficient to demonstrate safety, purity, and potency in 1 or more appropriate conditions of use for which the reference product is licensed and intended to be used

and for which licensure is sought for the biological product;

''(II) the biological product and reference product utilize the same mechanism or mechanisms of action for the condition or conditions of use prescribed, recommended, or suggested in the proposed labeling, but only to the extent the mechanism or mechanisms of action are known for the reference product;

''(III) the condition or conditions of use prescribed, recommended, or suggested in the labeling proposed for the biological product have been previously approved for the reference product;

''(IV) the route of administration, the dosage form, and the strength of the biological product are the same as those of the reference product; and

''(V) the facility in which the biological product is manufactured, processed, packed, or held meets stand-

ards designed to assure that the biological product continues to be safe, pure, and potent.

''(ii) DETERMINATION BY SECRETARY.—The Secretary may determine, in the Secretary's discretion, that an element described in clause (i)(I) is unnecessary in an application submitted under this subsection.

''(iii) ADDITIONAL INFORMATION.—An application submitted under this subsection—

''(I) shall include publicly available information regarding the Secretary's previous determination that the reference product is safe, pure, and potent; and

''(II) may include any additional information in support of the application, including publicly available information with respect to the reference product or another biological product.

''(B) INTERCHANGEABILITY.—An application (or a supplement to an application) submitted under this subsection may include infor-

mation demonstrating that the biological product meets the standards described in paragraph (4).

''(3) EVALUATION BY SECRETARY.—Upon review of an application (or a supplement to an application) submitted under this subsection, the Secretary shall license the biological product under this subsection if—

''(A) the Secretary determines that the information submitted in the application (or the supplement) is sufficient to show that the biological product—

''(i) is biosimilar to the reference product; or

''(ii) meets the standards described in paragraph (4), and therefore is interchangeable with the reference product; and

''(B) the applicant (or other appropriate person) consents to the inspection of the facility that is the subject of the application, in accordance with subsection (c).

''(4) SAFETY STANDARDS FOR DETERMINING INTERCHANGEABILITY.—Upon review of an application submitted under this subsection or any supplement to such application, the Secretary shall deter-

mine the biological product to be interchangeable with the reference product if the Secretary determines that the information submitted in the application (or a supplement to such application) is sufficient to show that—

''(A) the biological product—

''(i) is biosimilar to the reference product; and

''(ii) can be expected to produce the same clinical result as the reference product in any given patient; and

''(B) for a biological product that is administered more than once to an individual, the risk in terms of safety or diminished efficacy of alternating or switching between use of the biological product and the reference product is not greater than the risk of using the reference product without such alternation or switch.

''(5) GENERAL RULES.—

''(A) ONE REFERENCE PRODUCT PER APPLICATION.—A biological product, in an application submitted under this subsection, may not be evaluated against more than 1 reference product.

''(B) REVIEW.—An application submitted under this subsection shall be reviewed by the division within the Food and Drug Administration that is responsible for the review and approval of the application under which the reference product is licensed.

''(C) RISK EVALUATION AND MITIGATION STRATEGIES.—The authority of the Secretary with respect to risk evaluation and mitigation strategies under the Federal Food, Drug, and Cosmetic Act shall apply to biological products licensed under this subsection in the same manner as such authority applies to biological products licensed under subsection (a).

''(D) RESTRICTIONS ON BIOLOGICAL PRODUCTS CONTAINING DANGEROUS INGREDIENTS.—If information in an application submitted under this subsection, in a supplement to such an application, or otherwise available to the Secretary shows that a biological product—

''(i) is, bears, or contains a select agent or toxin listed in section 73.3 or 73.4 of title 42, section 121.3 or 121.4 of title 9, or section 331.3 of title 7, Code of

Federal Regulations (or any successor regulations); or

''(ii) is, bears, or contains a controlled substance in schedule I or II of section 202 of the Controlled Substances Act, as listed in part 1308 of title 21, Code of Federal Regulations (or any successor regulations);

the Secretary shall not license the biological product under this subsection unless the Secretary determines, after consultation with appropriate national security and drug enforcement agencies, that there would be no increased risk to the security or health of the public from licensing such biological product under this subsection.

''(6) EXCLUSIVITY FOR FIRST INTERCHANGEABLE BIOLOGICAL PRODUCT.—Upon review of an application submitted under this subsection relying on the same reference product for which a prior biological product has received a determination of interchangeability for any condition of use, the Secretary shall not make a determination under paragraph (4) that the second or subsequent biological product is

interchangeable for any condition of use until the earlier of—

''(A) 1 year after the first commercial marketing of the first interchangeable biosimilar biological product to be approved as interchangeable for that reference product;

''(B) 18 months after—

''(i) a final court decision on all patents in suit in an action instituted under subsection (l)(5) against the applicant that submitted the application for the first approved interchangeable biosimilar biological product; or

''(ii) the dismissal with or without prejudice of an action instituted under subsection (l)(5) against the applicant that submitted the application for the first approved interchangeable biosimilar biological product; or

''(C)(i) 42 months after approval of the first interchangeable biosimilar biological product if the applicant that submitted such application has been sued under subsection (l)(5) and such litigation is still ongoing within such 42-month period; or

''(ii) 18 months after approval of the first interchangeable biosimilar biological product if the applicant that submitted such application has not been sued under subsection (l)(5).

For purposes of this paragraph, the term 'final court decision' means a final decision of a court from which no appeal (other than a petition to the United States Supreme Court for a writ of certiorari) has been or can be taken.

''(7) EXCLUSIVITY FOR REFERENCE PRODUCT.—

''(A) EFFECTIVE DATE OF BIOSIMILAR APPLICATION APPROVAL.—Approval of an application under this subsection may not be made effective by the Secretary until the date that is 12 years after the date on which the reference product was first licensed under subsection (a).

''(B) FILING PERIOD.—An application under this subsection may not be submitted to the Secretary until the date that is 4 years after the date on which the reference product was first licensed under subsection (a).

''(C) FIRST LICENSURE.—Subparagraphs (A) and (B) shall not apply to a license for or approval of—

''(i) a supplement for the biological product that is the reference product; or

''(ii) a subsequent application filed by the same sponsor or manufacturer of the biological product that is the reference product (or a licensor, predecessor in interest, or other related entity) for—

''(I) a change (not including a modification to the structure of the biological product) that results in a new indication, route of administration, dosing schedule, dosage form, delivery system, delivery device, or strength; or

''(II) a modification to the structure of the biological product that does not result in a change in safety, purity, or potency.

''(8) PEDIATRIC STUDIES.—

''(A) EXCLUSIVITY.—If, before or after licensure of the reference product under subsection (a) of this section, the Secretary determines that information relating to the use of such product in the pediatric population may produce health benefits in that population, the Secretary makes a written request for pediatric

studies (which shall include a timeframe for completing such studies), the applicant or holder of the approved application agrees to the request, such studies are completed using appropriate formulations for each age group for which the study is requested within any such timeframe, and the reports thereof are submitted and accepted in accordance with section 505A(d)(3) of the Federal Food, Drug, and Cosmetic Act the period referred to in paragraph (7)(A) of this subsection is deemed to be 12 years and 6 months rather than 12 years.

''(B) EXCEPTION.—The Secretary shall not extend the period referred to in subparagraph (A) of this paragraph if the determination under section 505A(d)(3) of the Federal Food, Drug, and Cosmetic Act is made later than 9 months prior to the expiration of such period.

''(C) APPLICATION OF CERTAIN PROVISIONS.—The provisions of subsections (a), (d), (e), (f), (h), (j), (k), and (l) of section 505A of the Federal Food, Drug, and Cosmetic Act shall apply with respect to the extension of a period under subparagraph (A) of this para-

graph to the same extent and in the same manner as such provisions apply with respect to the extension of a period under subsection (b) or (c) of section 505A of the Federal Food, Drug, and Cosmetic Act.

''(9) GUIDANCE DOCUMENTS.—

''(A) IN GENERAL.—The Secretary may, after opportunity for public comment, issue guidance in accordance, except as provided in subparagraph (B)(i), with section 701(h) of the Federal Food, Drug, and Cosmetic Act with respect to the licensure of a biological product under this subsection. Any such guidance may be general or specific.

''(B) PUBLIC COMMENT.—

''(i) IN GENERAL.—The Secretary shall provide the public an opportunity to comment on any proposed guidance issued under subparagraph (A) before issuing final guidance.

''(ii) INPUT REGARDING MOST VALUABLE GUIDANCE.—The Secretary shall establish a process through which the public may provide the Secretary with input regarding priorities for issuing guidance.

''(C) NO REQUIREMENT FOR APPLICATION CONSIDERATION.—The issuance (or non-issuance) of guidance under subparagraph (A) shall not preclude the review of, or action on, an application submitted under this subsection.

''(D) REQUIREMENT FOR PRODUCT CLASS-SPECIFIC GUIDANCE.—If the Secretary issues product class-specific guidance under subparagraph (A), such guidance shall include a description of—

''(i) the criteria that the Secretary will use to determine whether a biological product is highly similar to a reference product in such product class; and

''(ii) the criteria, if available, that the Secretary will use to determine whether a biological product meets the standards described in paragraph (4).

''(E) CERTAIN PRODUCT CLASSES.—

''(i) GUIDANCE.—The Secretary may indicate in a guidance document that the science and experience, as of the date of such guidance, with respect to a product or product class (not including any recombinant protein) does not allow approval of

an application for a license as provided under this subsection for such product or product class.

''(ii) MODIFICATION OR REVERSAL.—The Secretary may issue a subsequent guidance document under subparagraph (A) to modify or reverse a guidance document under clause (i).

''(iii) NO EFFECT ON ABILITY TO DENY LICENSE.—Clause (i) shall not be construed to require the Secretary to approve a product with respect to which the Secretary has not indicated in a guidance document that the science and experience, as described in clause (i), does not allow approval of such an application.

''(10) NAMING.—The Secretary shall ensure that the labeling and packaging of each biological product licensed under this subsection bears a name that uniquely identifies the biological product and distinguishes it from the reference product and any other biological products licensed under this subsection following evaluation against such reference product.

''(l) PATENT NOTICES; RELATIONSHIP TO FINAL APPROVAL.—

''(1) DEFINITIONS.—For the purposes of this subsection, the term—

''(A) 'biosimilar product' means the biological product that is the subject of the application under subsection (k);

''(B) 'relevant patent' means a patent that—

''(i) expires after the date specified in subsection (k)(7)(A) that applies to the reference product; and

''(ii) could reasonably be asserted against the applicant due to the unauthorized making, use, sale, or offer for sale within the United States, or the importation into the United States of the biosimilar product, or materials used in the manufacture of the biosimilar product, or due to a use of the biosimilar product in a method of treatment that is indicated in the application;

''(C) 'reference product sponsor' means the holder of an approved application or license for the reference product; and

''(D) 'interested third party' means a person other than the reference product sponsor that owns a relevant patent, or has the right to commence or participate in an action for infringement of a relevant patent.

''(2) HANDLING OF CONFIDENTIAL INFORMATION.—Any entity receiving confidential information pursuant to this subsection shall designate one or more individuals to receive such information. Each individual so designated shall execute an agreement in accordance with regulations promulgated by the Secretary. The regulations shall require each such individual to take reasonable steps to maintain the confidentiality of information received pursuant to this subsection and use the information solely for purposes authorized by this subsection. The obligations imposed on an individual who has received confidential information pursuant to this subsection shall continue until the individual returns or destroys the confidential information, a court imposes a protective order that governs the use or handling of the confidential information, or the party providing the confidential information agrees to other terms or conditions regarding the handling or use of the confidential information.

''(3) PUBLIC NOTICE BY SECRETARY.—Within 30 days of acceptance by the Secretary of an application filed under subsection (k), the Secretary shall publish a notice identifying—

''(A) the reference product identified in the application; and

''(B) the name and address of an agent designated by the applicant to receive notices pursuant to paragraph (4)(B).

''(4) EXCHANGES CONCERNING PATENTS.—

''(A) EXCHANGES WITH REFERENCE PRODUCT SPONSOR.—

''(i) Within 30 days of the date of acceptance of the application by the Secretary, the applicant shall provide the reference product sponsor with a copy of the application and information concerning the biosimilar product and its production. This information shall include a detailed description of the biosimilar product, its method of manufacture, and the materials used in the manufacture of the product.

''(ii) Within 60 days of the date of receipt of the information required to be provided under clause (i), the reference prod-

uct sponsor shall provide to the applicant a list of relevant patents owned by the reference product sponsor, or in respect of which the reference product sponsor has the right to commence an action of infringement or otherwise has an interest in the patent as such patent concerns the biosimilar product.

''(iii) If the reference product sponsor is issued or acquires an interest in a relevant patent after the date on which the reference product sponsor provides the list required by clause (ii) to the applicant, the reference product sponsor shall identify that patent to the applicant within 30 days of the date of issue of the patent, or the date of acquisition of the interest in the patent, as applicable.

''(B) EXCHANGES WITH INTERESTED THIRD PARTIES.—

''(i) At any time after the date on which the Secretary publishes a notice for an application under paragraph (3), any interested third party may provide notice to the designated agent of the applicant

that the interested third party owns or has rights under 1 or more patents that may be relevant patents. The notice shall identify at least 1 patent and shall designate an individual who has executed an agreement in accordance with paragraph (2) to receive confidential information from the applicant.

''(ii) Within 30 days of the date of receiving notice pursuant to clause (i), the applicant shall send to the individual designated by the interested third party the information specified in subparagraph (A)(i), unless the applicant and interested third party otherwise agree.

''(iii) Within 90 days of the date of receiving information pursuant to clause (ii), the interested third party shall provide to the applicant a list of relevant patents which the interested third party owns, or in respect of which the interested third party has the right to commence or participate in an action for infringement.

''(iv) If the interested third party is issued or acquires an interest in a relevant

patent after the date on which the interested third party provides the list required by clause (iii), the interested third party shall identify that patent within 30 days of the date of issue of the patent, or the date of acquisition of the interest in the patent, as applicable.

''(C) IDENTIFICATION OF BASIS FOR INFRINGEMENT.—For any patent identified under clause (ii) or (iii) of subparagraph (A) or under clause (iii) or (iv) of subparagraph (B), the reference product sponsor or the interested third party, as applicable—

''(i) shall explain in writing why the sponsor or the interested third party believes the relevant patent would be infringed by the making, use, sale, or offer for sale within the United States, or importation into the United States, of the biosimilar product or by a use of the biosimilar product in treatment that is indicated in the application;

''(ii) may specify whether the relevant patent is available for licensing; and

''(iii) shall specify the number and date of expiration of the relevant patent.

''(D) CERTIFICATION BY APPLICANT CONCERNING IDENTIFIED RELEVANT PATENTS.—Not later than 45 days after the date on which a patent is identified under clause (ii) or (iii) of subparagraph (A) or under clause (iii) or (iv) of subparagraph (B), the applicant shall send a written statement regarding each identified patent to the party that identified the patent. Such statement shall either—

''(i) state that the applicant will not commence marketing of the biosimilar product and has requested the Secretary to not grant final approval of the application before the date of expiration of the noticed patent; or

''(ii) provide a detailed written explanation setting forth the reasons why the applicant believes—

''(I) the making, use, sale, or offer for sale within the United States, or the importation into the United States, of the biosimilar product, or the use of the biosimilar prod-

uct in a treatment indicated in the application, would not infringe the patent; or

''(II) the patent is invalid or unenforceable.

''(5) ACTION FOR INFRINGEMENT INVOLVING REFERENCE PRODUCT SPONSOR.—If an action for infringement concerning a relevant patent identified by the reference product sponsor under clause (ii) or (iii) of paragraph (4)(A), or by an interested third party under clause (iii) or (iv) of paragraph (4)(B), is brought within 60 days of the date of receipt of a statement under paragraph (4)(D)(ii), and the court in which such action has been commenced determines the patent is infringed prior to the date applicable under subsection (k)(7)(A) or (k)(8), the Secretary shall make approval of the application effective on the day after the date of expiration of the patent that has been found to be infringed. If more than one such patent is found to be infringed by the court, the approval of the application shall be made effective on the day after the date that the last such patent expires.

''(6) NOTIFICATION OF AGREEMENTS.—

''(A) REQUIREMENTS.—

''(i) AGREEMENT BETWEEN BIOSIMILAR PRODUCT APPLICANT AND REFERENCE PRODUCT SPONSOR.—If a biosimilar product applicant under subsection (k) and the reference product sponsor enter into an agreement described in subparagraph (B), the applicant and sponsor shall each file the agreement in accordance with subparagraph (C).

''(ii) AGREEMENT BETWEEN BIOSIMILAR PRODUCT APPLICANTS.—If 2 or more biosimilar product applicants submit an application under subsection (k) for biosimilar products with the same reference product and enter into an agreement described in subparagraph (B), the applicants shall each file the agreement in accordance with subparagraph (C).

''(B) SUBJECT MATTER OF AGREEMENT.—An agreement described in this subparagraph—

''(i) is an agreement between the biosimilar product applicant under subsection (k) and the reference product sponsor or between 2 or more biosimilar product ap-

plicants under subsection (k) regarding the manufacture, marketing, or sale of—

"(I) the biosimilar product (or biosimilar products) for which an application was submitted; or

"(II) the reference product;

"(ii) includes any agreement between the biosimilar product applicant under subsection (k) and the reference product sponsor or between 2 or more biosimilar product applicants under subsection (k) that is contingent upon, provides a contingent condition for, or otherwise relates to an agreement described in clause (i); and

"(iii) excludes any agreement that solely concerns—

"(I) purchase orders for raw material supplies;

"(II) equipment and facility contracts;

"(III) employment or consulting contracts; or

"(IV) packaging and labeling contracts.

"(C) FILING.—

"(i) IN GENERAL.—The text of an agreement required to be filed by subparagraph (A) shall be filed with the Assistant Attorney General and the Federal Trade Commission not later than—

"(I) 10 business days after the date on which the agreement is executed; and

"(II) prior to the date of the first commercial marketing of, for agreements described in subparagraph (A)(i), the biosimilar product that is the subject of the application or, for agreements described in subparagraph (A)(ii), any biosimilar product that is the subject of an application described in such subparagraph.

"(ii) IF AGREEMENT NOT REDUCED TO TEXT.—If an agreement required to be filed by subparagraph (A) has not been reduced to text, the persons required to file the agreement shall each file written descriptions of the agreement that are sufficient to disclose all the terms and conditions of the agreement.

''(iii) CERTIFICATION.—The chief executive officer or the company official responsible for negotiating any agreement required to be filed by subparagraph (A) shall include in any filing under this paragraph a certification as follows: 'I declare under penalty of perjury that the following is true and correct: The materials filed with the Federal Trade Commission and the Department of Justice under section 351(l)(6) of the Public Health Service Act, with respect to the agreement referenced in this certification: (1) represent the complete, final, and exclusive agreement between the parties; (2) include any ancillary agreements that are contingent upon, provide a contingent condition for, or are otherwise related to, the referenced agreement; and (3) include written descriptions of any oral agreements, representations, commitments, or promises between the parties that are responsive to such section and have not been reduced to writing.'.

''(D) DISCLOSURE EXEMPTION.—Any information or documentary material filed with

the Assistant Attorney General or the Federal Trade Commission pursuant to this paragraph shall be exempt from disclosure under section 552 of title 5, United States Code, and no such information or documentary material may be made public, except as may be relevant to any administrative or judicial action or proceeding. Nothing in this subparagraph prevents disclosure of information or documentary material to either body of the Congress or to any duly authorized committee or subcommittee of the Congress.

''(E) ENFORCEMENT.—

''(i) CIVIL PENALTY.—Any person that violates a provision of this paragraph shall be liable for a civil penalty of not more than $11,000 for each day on which the violation occurs. Such penalty may be recovered in a civil action—

''(I) brought by the United States; or

''(II) brought by the Federal Trade Commission in accordance with the procedures established in section

16(a)(1) of the Federal Trade Commission Act.

''(ii) COMPLIANCE AND EQUITABLE RELIEF.—If any person violates any provision of this paragraph, the United States district court may order compliance, and may grant such other equitable relief as the court in its discretion determines necessary or appropriate, upon application of the Assistant Attorney General or the Federal Trade Commission.

''(F) RULEMAKING.—The Federal Trade Commission, with the concurrence of the Assistant Attorney General and by rule in accordance with section 553 of title 5, United States Code, consistent with the purposes of this paragraph—

''(i) may define the terms used in this paragraph;

''(ii) may exempt classes of persons or agreements from the requirements of this paragraph; and

''(iii) may prescribe such other rules as may be necessary and appropriate to carry out the purposes of this paragraph.

''(G) SAVINGS CLAUSE.—Any action taken by the Assistant Attorney General or the Federal Trade Commission, or any failure of the Assistant Attorney General or the Commission to take action, under this paragraph shall not at any time bar any proceeding or any action with respect to any agreement between a biosimilar product applicant under subsection (k) and the reference product sponsor, or any agreement between biosimilar product applicants under subsection (k), under any other provision of law, nor shall any filing under this paragraph constitute or create a presumption of any violation of any competition laws.''.

(b) DEFINITIONS.—Section 351(i) of the Public Health Service Act (42 U.S.C. 262(i)) is amended—

(1) by striking ''In this section, the term 'biological product' means'' and inserting the following: ''In this section:

''(1) The term 'biological product' means'';

(2) in paragraph (1), as so designated, by inserting ''protein (except any chemically synthesized polypeptide),'' after ''allergenic product,''; and

(3) by adding at the end the following:

''(2) The term 'biosimilar' or 'biosimilarity', in reference to a biological product that is the subject of an application under subsection (k), means—

''(A) that the biological product is highly similar to the reference product notwithstanding minor differences in clinically inactive components; and

''(B) there are no clinically meaningful differences between the biological product and the reference product in terms of the safety, purity, and potency of the product.

''(3) The term 'interchangeable' or 'interchangeability', in reference to a biological product that is shown to meet the standards described in subsection (k)(4), means that the biological product may be substituted for the reference product without the intervention of the health care provider who prescribed the reference product.

''(4) The term 'reference product' means the single biological product licensed under subsection (a) against which a biological product is evaluated in an application submitted under subsection (k).''.

(c) PRODUCTS PREVIOUSLY APPROVED UNDER SECTION 505.—

(1) REQUIREMENT TO FOLLOW SECTION 351.—Except as provided in paragraph (2), an application for a biological product shall be submitted under section 351 of the Public Health Service Act (42 U.S.C. 262) (as amended by this Act).

(2) EXCEPTION.—An application for a biological product may be submitted under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) if—

(A) such biological product is in a product class for which a biological product in such product class is the subject of an application approved under such section 505 not later than the date of enactment of this Act; and

(B) such application—

(i) has been submitted to the Secretary of Health and Human Services (referred to in this Act as the ''Secretary'') before the date of enactment of this Act; or

(ii) is submitted to the Secretary not later than the date that is 10 years after the date of enactment of this Act.

(3) LIMITATION.—Notwithstanding paragraph (2), an application for a biological product may not

be submitted under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) if there is another biological product approved under subsection (a) of section 351 of the Public Health Service Act that could be a reference product with respect to such application (within the meaning of such section 351) if such application were submitted under subsection (k) of such section 351.

(4) DEEMED APPROVED UNDER SECTION 351.—An approved application for a biological product under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) shall be deemed to be a license for the biological product under such section 351 on the date that is 10 years after the date of enactment of this Act.

(5) DEFINITIONS.—For purposes of this subsection, the term ''biological product'' has the meaning given such term under section 351 of the Public Health Service Act (42 U.S.C. 262) (as amended by this Act).

SEC. 2576. FEES RELATING TO BIOSIMILAR BIOLOGICAL PRODUCTS.

Subparagraph (B) of section 735(1) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 379g(1)) is amended by inserting '', including licensure of a biological

product under section 351(k) of such Act'' before the period at the end.

SEC. 2577. AMENDMENTS TO CERTAIN PATENT PROVISIONS.

(a) Section 271(e)(2) of title 35, United States Code is amended—

(1) in subparagraph (A), by striking ''or'' after ''patent,'';

(2) in subparagraph (B), by adding ''or'' after the comma at the end;

(3) by inserting the following after subparagraph (B):

''(C) a statement under section 351(l)(4)(D)(ii) of the Public Health Service Act,''; and

(4) in the matter following subparagraph (C) (as added by paragraph (3)), by inserting before the period the following: '', or if the statement described in subparagraph (C) is provided in connection with an application to obtain a license to engage in the commercial manufacture, use, or sale of a biological product claimed in a patent or the use of which is claimed in a patent before the expiration of such patent''.

(b) Section 271(e)(4) of title 35, United States Code, is amended by striking ''in paragraph (2)'' in both places it appears and inserting ''in paragraph (2)(A) or (2)(B)''.

Subtitle D—Community Living Assistance Services and Supports

SEC. 2581. ESTABLISHMENT OF NATIONAL VOLUNTARY INSURANCE PROGRAM FOR PURCHASING COMMUNITY LIVING ASSISTANCE SERVICES AND SUPPORT (CLASS PROGRAM).

(a) ESTABLISHMENT OF CLASS PROGRAM.—The Public Health Service Act (42 U.S.C. 201 et seq.), as amended by section 2301, is amended by adding at the end the following:

''TITLE XXXII—COMMUNITY LIVING ASSISTANCE SERVICES AND SUPPORTS

''SEC. 3201. PURPOSE.

''The purpose of this title is to establish a national voluntary insurance program for purchasing community living assistance services and supports in order to—

''(1) provide individuals with functional limitations with tools that will allow them to maintain their personal and financial independence and live in the community through a new financing strategy for community living assistance services and supports;

''(2) establish an infrastructure that will help address the Nation's community living assistance services and supports needs;

''(3) alleviate burdens on family caregivers; and

''(4) address institutional bias by providing a financing mechanism that supports personal choice and independence to live in the community.

"SEC. 3202. DEFINITIONS.

''In this title:

''(1) ACTIVE ENROLLEE.—The term 'active enrollee' means an individual who is enrolled in the CLASS program in accordance with section 3204 and who has paid any premiums due to maintain such enrollment.

''(2) ACTIVELY EMPLOYED.—The term 'actively employed' means an individual who—

''(A) is reporting for work at the individual's usual place of employment or at another location to which the individual is required to travel because of the individual's employment (or in the case of an individual who is a member of the uniformed services, is on active duty and is physically able to perform the duties of the individual's position); and

''(B) is able to perform all the usual and customary duties of the individual's employment on the individual's regular work schedule.

''(3) ACTIVITIES OF DAILY LIVING.—The term 'activities of daily living' has the meaning given the term in section 7702B(c)(2)(B) of the Internal Revenue Code of 1986.

''(4) CLASS PROGRAM.—The term 'CLASS program' means the program established under this title.

''(5) ELIGIBILITY ASSESSMENT SYSTEM.—The term 'Eligibility Assessment System' means the entity designated by the Secretary under section 3205(a)(2)(A)(i).

''(6) ELIGIBLE BENEFICIARY.—

''(A) IN GENERAL.—The term 'eligible beneficiary' means any individual who is an active enrollee in the CLASS program and, as of the date described in subparagraph (B)—

''(i) has paid premiums for enrollment in such program for at least 60 months;

''(ii) has earned, for each calendar year that occurs during the first 60 months for which the individual has paid premiums for enrollment in the program,

at least an amount equal to the amount of wages and self-employment income which an individual must have in order to be credited with a quarter of coverage under section 213(d) of the Social Security Act for that year; and

''(iii) has paid premiums for enrollment in such program for at least 24 consecutive months, if a lapse in premium payments of more than 3 months has occurred during the period that begins on the date of the individual's enrollment and ends on the date of such determination.

''(B) DATE DESCRIBED.—For purposes of subparagraph (A), the date described in this subparagraph is the date on which the individual is determined to have a functional limitation described in section 3203(a)(1)(C) that is expected to last for a continuous period of more than 90 days.

''(C) REGULATIONS.—The Secretary shall promulgate regulations specifying exceptions to the minimum earnings requirements under subparagraph (A)(ii) for purposes of being consid-

ered an eligible beneficiary for certain populations.

''(7) HOSPITAL; NURSING FACILITY; INTERMEDIATE CARE FACILITY FOR THE MENTALLY RETARDED; INSTITUTION FOR MENTAL DISEASES.—The terms 'hospital', 'nursing facility', 'intermediate care facility for the mentally retarded', and 'institution for mental diseases' have the meanings given such terms for purposes of Medicaid.

''(8) CLASS INDEPENDENCE ADVISORY COUNCIL.—The term 'CLASS Independence Advisory Council' or 'Council' means the Advisory Council established under section 3207 to advise the Secretary.

''(9) CLASS INDEPENDENCE BENEFIT PLAN.—The term 'CLASS Independence Benefit Plan' means the benefit plan developed and designated by the Secretary in accordance with section 3203.

''(10) CLASS INDEPENDENCE FUND.—The term 'CLASS Independence Fund' or 'Fund' means the fund established under section 3206.

''(11) MEDICAID.—The term 'Medicaid' means the program established under title XIX of the Social Security Act.

''(12) PROTECTION AND ADVOCACY SYSTEM.—The term 'Protection and Advocacy System' means

the system for each State established under section 143 of the Developmental Disabilities Assistance and Bill of Rights Act of 2000.

"SEC. 3203. CLASS INDEPENDENCE BENEFIT PLAN.

"(a) PROCESS FOR DEVELOPMENT.—

"(1) IN GENERAL.—The Secretary, in consultation with appropriate actuaries and other experts, shall develop at least 3 actuarially sound benefit plans as alternatives for consideration for designation by the Secretary as the CLASS Independence Benefit Plan under which eligible beneficiaries shall receive benefits under this title. Each of the plan alternatives developed shall be designed to provide eligible beneficiaries with the benefits described in section 3205 consistent with the following requirements:

"(A) PREMIUMS.—Beginning with the first year of the CLASS program, and for each year thereafter, the Secretary shall establish all premiums to be paid by enrollees for the year based on an actuarial analysis of the 75-year costs of the program that ensures solvency throughout such 75-year period.

"(B) VESTING PERIOD.—A 5-year vesting period for eligibility for benefits.

''(C) BENEFIT TRIGGERS.—A benefit trigger for provision of benefits that requires a determination that an individual has a functional limitation, as certified by a licensed health care practitioner, described in any of the following clauses that is expected to last for a continuous period of more than 90 days:

''(i) The individual is determined to be unable to perform at least the minimum number (which may be 2 or 3) of activities of daily living as are required under the plan for the provision of benefits without substantial assistance (as defined by the Secretary) from another individual.

''(ii) The individual requires substantial supervision to protect the individual from threats to health and safety due to substantial cognitive impairment.

''(iii) The individual has a level of functional limitation similar (as determined under regulations prescribed by the Secretary) to the level of functional limitation described in clause (i) or (ii).

''(D) CASH BENEFIT.—Payment of a cash benefit that satisfies the following requirements:

''(i) MINIMUM REQUIRED AMOUNT.—The benefit amount provides an eligible beneficiary with not less than an average of $50 per day (as determined based on the reasonably expected distribution of beneficiaries receiving benefits at various benefit levels).

''(ii) AMOUNT SCALED TO FUNCTIONAL ABILITY.—The benefit amount is varied based on a scale of functional ability, with not less than 2, and not more than 6, benefit level amounts.

''(iii) DAILY OR WEEKLY.—The benefit is paid on a daily or weekly basis.

''(iv) NO LIFETIME OR AGGREGATE LIMIT.—The benefit is not subject to any lifetime or aggregate limit.

''(2) REVIEW AND RECOMMENDATION BY THE CLASS INDEPENDENCE ADVISORY COUNCIL.—The CLASS Independence Advisory Council shall—

''(A) evaluate the alternative benefit plans developed under paragraph (1); and

''(B) recommend for designation as the CLASS Independence Benefit Plan for offering to the public the plan that the Council deter-

mines best balances price and benefits to meet enrollees' needs in an actuarially sound manner, while optimizing the probability of the long-term sustainability of the CLASS program.

''(3) DESIGNATION BY THE SECRETARY.—Not later than October 1, 2012, the Secretary, taking into consideration the recommendation of the CLASS Independence Advisory Council under paragraph (2)(B), shall designate a benefit plan as the CLASS Independence Benefit Plan. The Secretary shall publish such designation, along with details of the plan and the reasons for the selection by the Secretary, in a final rule that allows for a period of public comment.

''(b) ADDITIONAL PREMIUM REQUIREMENTS.—

''(1) ADJUSTMENT OF PREMIUMS.—

''(A) IN GENERAL.—Except as provided in subparagraphs (B), (C), (D), and (E), the amount of the monthly premium determined for an individual upon such individual's enrollment in the CLASS program shall remain the same for as long as the individual is an active enrollee in the program.

''(B) RECALCULATED PREMIUM IF REQUIRED FOR PROGRAM SOLVENCY.—

''(i) IN GENERAL.—Subject to clause (ii), if the Secretary determines, based on the most recent report of the Board of Trustees of the CLASS Independence Fund, the advice of the CLASS Independence Advisory Council, and the annual report of the Inspector General of the Department of Health and Human Services, and waste, fraud, and abuse, or such other information as the Secretary determines appropriate, that the monthly premiums and income to the CLASS Independence Fund for a year are projected to be insufficient with respect to the 20-year period that begins with that year, the Secretary shall adjust the monthly premiums for individuals enrolled in the CLASS program as necessary.

''(ii) EXEMPTION FROM INCREASE.—Any increase in a monthly premium imposed as result of a determination described in clause (i) shall not apply with respect to the monthly premium of any active enrollee who—

''(I) has attained age 65;

''(II) has paid premiums for enrollment in the program for at least 20 years; and

''(III) is not actively employed.

''(C) RECALCULATED PREMIUM IF REENROLLMENT AFTER MORE THAN A 3-MONTH LAPSE.—

''(i) IN GENERAL.—The reenrollment of an individual after a 90-day period during which the individual failed to pay the monthly premium required to maintain the individual's enrollment in the CLASS program shall be treated as an initial enrollment for purposes of age-adjusting the premium for enrollment in the program.

''(ii) CREDIT FOR PRIOR MONTHS IF REENROLLED WITHIN 5 YEARS.—An individual who reenrolls in the CLASS program after such a 90-day period and before the end of the 5-year period that begins with the first month for which the individual failed to pay the monthly premium required to maintain the individual's enrollment in the program shall be—

''(I) credited with any months of paid premiums that accrued prior to the individual's lapse in enrollment; and

''(II) notwithstanding the total amount of any such credited months, required to satisfy section 3202(6)(A)(ii) before being eligible to receive benefits.

''(D) PENALTY FOR REENROLLMENT AFTER 5-YEAR LAPSE.—In the case of an individual who reenrolls in the CLASS program after the end of the 5-year period described in subparagraph (C)(ii), the monthly premium required for the individual shall be the age-adjusted premium that would be applicable to an initially enrolling individual who is the same age as the reenrolling individual, increased by the greater of—

''(i) an amount that the Secretary determines is actuarially sound for each month that occurs during the period that begins with the first month for which the individual failed to pay the monthly premium required to maintain the individual's

enrollment in the CLASS program and ends with the month preceding the month in which the reenrollment is effective; or

''(ii) 1 percent of the applicable age-adjusted premium for each such month occurring in such period.

''(2) ADMINISTRATIVE EXPENSES.—In determining the monthly premiums for the CLASS program, the Secretary may factor in costs for administering the program, not to exceed—

''(A) in the case of the first 5 years in which the program is in effect under this title, an amount equal to 3 percent of all premiums paid during each such year; and

''(B) in the case of subsequent years, an amount equal to 5 percent of the total amount of all expenditures (including benefits paid) under this title with respect to that year.

''(3) NO UNDERWRITING REQUIREMENTS.—No underwriting (other than on the basis of age in accordance with paragraph (2)) shall be used to—

''(A) determine the monthly premium for enrollment in the CLASS program; or

''(B) prevent an individual from enrolling in the program.

"SEC. 3204. ENROLLMENT AND DISENROLLMENT REQUIREMENTS.

''(a) AUTOMATIC ENROLLMENT.—

''(1) IN GENERAL.—Subject to paragraph (2), the Secretary shall establish procedures under which each individual described in subsection (c) shall be automatically enrolled in the CLASS program by an employer of such individual under rules similar to the rules of sections 401(k)(13) and 414(w) of the Internal Revenue Code of 1986.

''(2) ALTERNATIVE ENROLLMENT PROCEDURES.—The procedures established under paragraph (1) shall provide for an alternative enrollment process for an individual described in subsection (c) in the case of such an individual—

''(A) who is self-employed;

''(B) who has more than 1 employer;

''(C) whose employer does not elect to participate in the automatic enrollment process established by the Secretary; or

''(D) who is a spouse described in subsection (c)(2) of who is not subject to automatic enrollment.

''(3) ADMINISTRATION.—

''(A) IN GENERAL.—The Secretary shall, by regulation, establish procedures to—

''(i) ensure that an individual is not automatically enrolled in the CLASS program by more than 1 employer; and

''(ii) allow for an individual's employer to deduct a premium for a spouse described in subsection (c)(1)(B) who is not subject to automatic enrollment.

''(B) FORM.—Enrollment in the CLASS program shall be made in such manner as the Secretary may prescribe in order to ensure ease of administration.

''(b) ELECTION TO OPT-OUT.—An individual described in subsection (c) may elect to waive enrollment in the CLASS program at any time in such form and manner as the Secretary shall prescribe.

''(c) INDIVIDUAL DESCRIBED.—For purposes of enrolling in the CLASS program, an individual described in this paragraph is—

''(1) an individual—

''(A) who has attained age 18;

''(B) who receives wages on which there is imposed a tax under section 3101(a) or 3201(a) of the Internal Revenue Code of 1986;

''(C) who is actively employed; and

''(D) who is not—

''(i) a patient in a hospital or nursing facility, an intermediate care facility for the mentally retarded, or an institution for mental diseases and receiving medical assistance under Medicaid; or

''(ii) confined in a jail, prison, other penal institution or correctional facility, or by court order pursuant to conviction of a criminal offense or in connection with a verdict or finding described in section 202(x)(1)(A)(ii) of the Social Security Act; or

''(2) the spouse of an individual described in paragraph (1) and who would be an individual so described but for subparagraph (B) or (C) of that paragraph.

''(d) RULE OF CONSTRUCTION.—Nothing in this title shall be construed as requiring an active enrollee to continue to satisfy subparagraph (B) or (C) of subsection (c)(1) in order to maintain enrollment in the CLASS program.

''(e) PAYMENT.—

''(1) PAYROLL DEDUCTION.—An amount equal to the monthly premium for the enrollment in the CLASS program of an individual shall be deducted

from the wages of such individual in accordance with such procedures as the Secretary shall establish for employers who elect to deduct and withhold such premiums on behalf of enrolled employees.

''(2) ALTERNATIVE PAYMENT MECHANISM.—The Secretary shall establish alternative procedures for the payment of monthly premiums by an individual enrolled in the CLASS program who does not have an employer who elects to deduct and withhold premiums in accordance with subparagraph (A).

''(f) TRANSFER OF PREMIUMS COLLECTED.—

''(1) IN GENERAL.—During each calendar year the Secretary of the Treasury shall deposit into the CLASS Independence Fund a total amount equal, in the aggregate, to 100 percent of the premiums collected during that year.

''(2) TRANSFERS BASED ON ESTIMATES.—The amount deposited pursuant to paragraph (1) shall be transferred in at least monthly payments to the CLASS Independence Fund on the basis of estimates by the Secretary and certified to the Secretary of the Treasury of the amounts collected in accordance with this section. Proper adjustments shall be made in amounts subsequently transferred

to the Fund to the extent prior estimates were in excess of, or were less than, actual amounts collected.

''(g) OTHER ENROLLMENT AND DISENROLLMENT OPPORTUNITIES.—The Secretary shall establish procedures under which—

''(1) an individual who, in the year of the individual's initial eligibility to enroll in the CLASS program, has elected to waive enrollment in the program, is eligible to elect to enroll in the program, in such form and manner as the Secretary shall establish, only during an open enrollment period established by the Secretary that is specific to the individual and that may not occur more frequently than biennially after the date on which the individual first elected to waive enrollment in the program; and

''(2) an individual shall only be permitted to disenroll from the program during an annual disenrollment period established by the Secretary and in such form and manner as the Secretary shall establish.

''SEC. 3205. BENEFITS.

''(a) DETERMINATION OF ELIGIBILITY.—

''(1) APPLICATION FOR RECEIPT OF BENEFITS.—The Secretary shall establish procedures under which an active enrollee shall apply for receipt

of benefits under the CLASS Independence Benefit Plan.

''(2) ELIGIBILITY ASSESSMENTS.—

''(A) IN GENERAL.—Not later than January 1, 2012, the Secretary shall—

''(i) designate an entity (other than a service with which the Commissioner of Social Security has entered into an agreement, with respect to any State, to make disability determinations for purposes of title II or XVI of the Social Security Act) to serve as an Eligibility Assessment System by providing for eligibility assessments of active enrollees who apply for receipt of benefits;

''(ii) enter into an agreement with the Protection and Advocacy System for each State to provide advocacy services in accordance with subsection (d); and

''(iii) enter into an agreement with public and private entities to provide advice and assistance counseling in accordance with subsection (e).

''(B) REGULATIONS.—The Secretary shall promulgate regulations to develop an expedited

nationally equitable eligibility determination process, as certified by a licensed health care practitioner, an appeals process, and a redetermination process, as certified by a licensed health care practitioner, including whether an applicant is eligible for a cash benefit under the program and if so, the amount of the cash benefit (in accordance the sliding scale established under the plan).

''(C) PRESUMPTIVE ELIGIBILITY FOR CERTAIN INSTITUTIONALIZED ENROLLEES PLANNING TO DISCHARGE.—An active enrollee shall be deemed presumptively eligible if the enrollee—

''(i) has applied for, and attests is eligible for, the maximum cash benefit available under the sliding scale established under the CLASS Independence Benefit Plan;

''(ii) is a patient in a hospital (but only if the hospitalization is for long-term care), nursing facility, intermediate care facility for the mentally retarded, or an institution for mental diseases; and

''(iii) is in the process of, or about to being the process of, planning to discharge from the hospital, facility, or institution, or within 60 days from the date of discharge from the hospital, facility, or institution.

''(D) APPEALS.—The Secretary shall establish procedures under which an applicant for benefits under the CLASS Independence Benefit Plan shall be guaranteed the right to appeal an adverse determination.

''(b) BENEFITS.—An eligible beneficiary shall receive the following benefits under the CLASS Independence Benefit Plan:

''(1) CASH BENEFIT.—A cash benefit established by the Secretary in accordance with the requirements of section 3203(a)(1)(D) that—

''(A) the first year in which beneficiaries receive the benefits under the plan, is not less than the average dollar amount specified in clause (i) of such section; and

''(B) for any subsequent year, is not less than the average per day dollar limit applicable under this subparagraph for the preceding year, increased by the percentage increase in the con-

sumer price index for all urban consumers (U.S. city average) over the previous year.

''(2) ADVOCACY SERVICES.—Advocacy services in accordance with subsection (d).

''(3) ADVICE AND ASSISTANCE COUNSELING.—Advice and assistance counseling in accordance with subsection (e).

''(4) ADMINISTRATIVE EXPENSES.—Advocacy services and advise and assistance counseling services under paragraphs (2) and (3) of this subsection shall be included as administrative expenses under section 3203(b)(2).

''(c) PAYMENT OF BENEFITS.—

''(1) LIFE INDEPENDENCE ACCOUNT.—

''(A) IN GENERAL.—The Secretary shall establish procedures for administering the provision of benefits to eligible beneficiaries under the CLASS Independence Benefit Plan, including the payment of the cash benefit for the beneficiary into a Life Independence Account established by the Secretary on behalf of each eligible beneficiary.

''(B) USE OF CASH BENEFITS.—Cash benefits paid into a Life Independence Account of an eligible beneficiary shall be used to purchase

nonmedical services and supports that the beneficiary needs to maintain his or her independence at home or in another residential setting of their choice in the community, including (but not limited to) home modifications, assistive technology, accessible transportation, homemaker services, respite care, personal assistance services, home care aides, and nursing support. Nothing in the preceding sentence shall prevent an eligible beneficiary from using cash benefits paid into a Life Independence Account for obtaining assistance with decisionmaking concerning medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives or other written instructions recognized under State law, such as a living will or durable power of attorney for health care, in the case that an injury or illness causes the individual to be unable to make health care decisions.

''(C) ELECTRONIC MANAGEMENT OF FUNDS.—The Secretary shall establish procedures for—

''(i) crediting an account established on behalf of a beneficiary with the beneficiary's cash daily benefit;

''(ii) allowing the beneficiary to access such account through debit cards; and

''(iii) accounting for withdrawals by the beneficiary from such account.

''(D) PRIMARY PAYOR RULES FOR BENEFICIARIES WHO ARE ENROLLED IN MEDICAID.—In the case of an eligible beneficiary who is enrolled in Medicaid, the following payment rules shall apply:

''(i) INSTITUTIONALIZED BENEFICIARY.—If the beneficiary is a patient in a hospital, nursing facility, intermediate care facility for the mentally retarded, or an institution for mental diseases, the beneficiary shall retain an amount equal to 5 percent of the beneficiary's daily or weekly cash benefit (as applicable) (which shall be in addition to the amount of the beneficiary's personal needs allowance provided under Medicaid), and the remainder of such benefit shall be applied toward the facility's cost of providing the beneficiary's

care, and Medicaid shall provide secondary coverage for such care.

''(ii) BENEFICIARIES RECEIVING HOME AND COMMUNITY-BASED SERVICES.—

''(I) 50 PERCENT OF BENEFIT RETAINED BY BENEFICIARY.—Subject to subclause (II), if a beneficiary is receiving medical assistance under Medicaid for home and community-based services, the beneficiary shall retain an amount equal to 50 percent of the beneficiary's daily or weekly cash benefit (as applicable), and the remainder of the daily or weekly cash benefit shall be applied toward the cost to the State of providing such assistance (and shall not be used to claim Federal matching funds under Medicaid), and Medicaid shall provide secondary coverage for the remainder of any costs incurred in providing such assistance.

''(II) REQUIREMENT FOR STATE OFFSET.—A State shall be paid the

remainder of a beneficiary's daily or weekly cash benefit under subclause (I) only if the State home and community-based waiver under section 1115 of the Social Security Act or subsection (c) or (d) of section 1915 of such Act, or the State plan amendment under subsection (i) of such section does not include a waiver of the requirements of section 1902(a)(1) of the Social Security Act (relating to statewideness) or of section 1902(a)(10)(B) of such Act (relating to comparability) and the State offers at a minimum case management services, personal care services, habilitation services, and respite care under such a waiver or State plan amendment.

''(III) DEFINITION OF HOME AND COMMUNITY-BASED SERVICES.—In this clause, the term 'home and community-based services' means any services which may be offered under a home and community-based waiver

authorized for a State under section 1115 of the Social Security Act or subsection (c) or (d) of section 1915 of such Act or under a State plan amendment under subsection (i) of such section.

''(iii) BENEFICIARIES ENROLLED IN PROGRAMS OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE).—

''(I) IN GENERAL.—Subject to subclause (II), if a beneficiary is receiving medical assistance under Medicaid for PACE program services under section 1934 of the Social Security Act, the beneficiary shall retain an amount equal to 50 percent of the beneficiary's daily or weekly cash benefit (as applicable), and the remainder of the daily or weekly cash benefit shall be applied toward the cost to the State of providing such assistance (and shall not be used to claim Federal matching funds under Medicaid), and Medicaid shall provide secondary coverage for the remainder of any

costs incurred in providing such assistance.

''(II) INSTITUTIONALIZED RECIPIENTS OF PACE PROGRAM SERVICES.—If a beneficiary receiving assistance under Medicaid for PACE program services is a patient in a hospital, nursing facility, intermediate care facility for the mentally retarded, or an institution for mental diseases, the beneficiary shall be treated as in institutionalized beneficiary under clause (i).

''(2) AUTHORIZED REPRESENTATIVES.—

''(A) IN GENERAL.—The Secretary shall establish procedures to allow access to a beneficiary's cash benefits by an authorized representative of the eligible beneficiary on whose behalf such benefits are paid.

''(B) QUALITY ASSURANCE AND PROTECTION AGAINST FRAUD AND ABUSE.—The procedures established under subparagraph (A) shall ensure that authorized representatives of eligible beneficiaries comply with standards of conduct established by the Secretary, including

standards requiring that such representatives provide quality services on behalf of such beneficiaries, do not have conflicts of interest, and do not misuse benefits paid on behalf of such beneficiaries or otherwise engage in fraud or abuse.

''(3) COMMENCEMENT OF BENEFITS.—Benefits shall be paid to, or on behalf of, an eligible beneficiary beginning with the first month in which an application for such benefits is approved.

''(4) ROLLOVER OPTION FOR LUMP-SUM PAYMENT.—An eligible beneficiary may elect to—

''(A) defer payment of their daily or weekly benefit and to rollover any such deferred benefits from month-to-month, but not from year-to-year; and

''(B) receive a lump-sum payment of such deferred benefits in an amount that may not exceed the lesser of—

''(i) the total amount of the accrued deferred benefits; or

''(ii) the applicable annual benefit.

''(5) PERIOD FOR DETERMINATION OF ANNUAL BENEFITS.—

''(A) IN GENERAL.—The applicable period for determining with respect to an eligible beneficiary the applicable annual benefit and the amount of any accrued deferred benefits is the 12-month period that commences with the first month in which the beneficiary began to receive such benefits, and each 12-month period thereafter.

''(B) INCLUSION OF INCREASED BENEFITS.—The Secretary shall establish procedures under which cash benefits paid to an eligible beneficiary that increase or decrease as a result of a change in the functional status of the beneficiary before the end of a 12-month benefit period shall be included in the determination of the applicable annual benefit paid to the eligible beneficiary.

''(C) RECOUPMENT OF UNPAID, ACCRUED BENEFITS.—

''(i) IN GENERAL.—The Secretary, in coordination with the Secretary of the Treasury, shall recoup any accrued benefits in the event of—

''(I) the death of a beneficiary; or

''(II) the failure of a beneficiary to elect under paragraph (4)(B) to receive such benefits as a lump-sum payment before the end of the 12-month period in which such benefits accrued.

''(ii) PAYMENT INTO CLASS INDEPENDENCE FUND.—Any benefits recouped in accordance with clause (i) shall be paid into the CLASS Independence Fund and used in accordance with section 3206.

''(6) REQUIREMENT TO RECERTIFY ELIGIBILITY FOR RECEIPT OF BENEFITS.—An eligible beneficiary shall periodically, as determined by the Secretary—

''(A) recertify by submission of medical evidence the beneficiary's continued eligibility for receipt of benefits; and

''(B) submit records of expenditures attributable to the aggregate cash benefit received by the beneficiary during the preceding year.

''(7) SUPPLEMENT, NOT SUPPLANT OTHER HEALTH CARE BENEFITS.—Subject to the Medicaid payment rules under paragraph (1)(D), benefits received by an eligible beneficiary shall supplement, but not supplant, other health care benefits for

which the beneficiary is eligible under Medicaid or any other Federally funded program that provides health care benefits or assistance.

''(d) ADVOCACY SERVICES.—An agreement entered into under subsection (a)(2)(A)(ii) shall require the Protection and Advocacy System for the State to—

''(1) assign, as needed, an advocacy counselor to each eligible beneficiary that is covered by such agreement and who shall provide an eligible beneficiary with—

''(A) information regarding how to access the appeals process established for the program;

''(B) assistance with respect to the annual recertification and notification required under subsection (c)(6); and

''(C) such other assistance with obtaining services as the Secretary, by regulation, shall require; and

''(2) ensure that the System and such counselors comply with the requirements of subsection (h).

''(e) ADVICE AND ASSISTANCE COUNSELING.—An agreement entered into under subsection (a)(2)(A)(iii) shall require the entity to assign, as requested by an eligible beneficiary that is covered by such agreement, an ad-

vice and assistance counselor who shall provide an eligible beneficiary with information regarding—

''(1) accessing and coordinating long-term services and supports in the most integrated setting;

''(2) possible eligibility for other benefits and services;

''(3) development of a service and support plan;

''(4) information about programs established under the Assistive Technology Act of 1998 and the services offered under such programs;

''(5) available assistance with decisionmaking concerning medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives or other written instructions recognized under State law, such as a living will or durable power of attorney for health care, in the case that an injury or illness causes the individual to be unable to make health care decisions; and

''(6) such other services as the Secretary, by regulation, may require.

''(f) NO EFFECT ON ELIGIBILITY FOR OTHER BENEFITS.—Benefits paid to an eligible beneficiary under the CLASS program shall be disregarded for purposes of determining or continuing the beneficiary's eligibility for re-

ceipt of benefits under any other Federal, State, or locally funded assistance program, including benefits paid under titles II, XVI, XVIII, XIX, or XXI of the Social Security Act, under the laws administered by the Secretary of Veterans Affairs, under low-income housing assistance programs, or under the supplemental nutrition assistance program established under the Food and Nutrition Act of 2008.

''(g) RULE OF CONSTRUCTION.—Nothing in this title shall be construed as prohibiting benefits paid under the CLASS Independence Benefit Plan from being used to compensate a family caregiver for providing community living assistance services and supports to an eligible beneficiary.

''(h) PROTECTION AGAINST CONFLICTS OF INTEREST.—The Secretary shall establish procedures to ensure that the Eligibility Assessment System, the Protection and Advocacy System for a State, advocacy counselors for eligible beneficiaries, and any other entities that provide services to active enrollees and eligible beneficiaries under the CLASS program comply with the following:

''(1) If the entity provides counseling or planning services, such services are provided in a manner that fosters the best interests of the active enrollee or beneficiary.

''(2) The entity has established operating procedures that are designed to avoid or minimize conflicts of interest between the entity and an active enrollee or beneficiary.

''(3) The entity provides information about all services and options available to the active enrollee or beneficiary, to the best of its knowledge, including services available through other entities or providers.

''(4) The entity assists the active enrollee or beneficiary to access desired services, regardless of the provider.

''(5) The entity reports the number of active enrollees and beneficiaries provided with assistance by age, disability, and whether such enrollees and beneficiaries received services from the entity or another entity.

''(6) If the entity provides counseling or planning services, the entity ensures that an active enrollee or beneficiary is informed of any financial interest that the entity has in a service provider.

''(7) The entity provides an active enrollee or beneficiary with a list of available service providers that can meet the needs of the active enrollee or beneficiary.

"SEC. 3206. CLASS INDEPENDENCE FUND.

"(a) ESTABLISHMENT OF CLASS INDEPENDENCE FUND.—There is established in the Treasury of the United States a trust fund to be known as the 'CLASS Independence Fund'. The Secretary of the Treasury shall serve as Managing Trustee of such Fund. The Fund shall consist of all amounts derived from payments into the Fund under sections 3204(f) and 3205(c)(5)(C)(ii), and remaining after investment of such amounts under subsection (b), including additional amounts derived as income from such investments. The amounts held in the Fund are appropriated and shall remain available without fiscal year limitation—

"(1) to be held for investment on behalf of individuals enrolled in the CLASS program;

"(2) to pay the administrative expenses related to the Fund and to investment under subsection (b); and

"(3) to pay cash benefits to eligible beneficiaries under the CLASS Independence Benefit Plan.

"(b) INVESTMENT OF FUND BALANCE.—The Secretary of the Treasury shall invest and manage the CLASS Independence Fund in the same manner, and to the same extent, as the Federal Supplementary Medical Insurance Trust Fund may be invested and managed

under subsections (c), (d), and (e) of section 1841(d) of the Social Security Act.

''(c) BOARD OF TRUSTEES.—

''(1) IN GENERAL.—With respect to the CLASS Independence Fund, there is hereby created a body to be known as the Board of Trustees of the CLASS Independence Fund (hereinafter in this section referred to as the 'Board of Trustees') composed of the Secretary of the Treasury, the Secretary of Labor, and the Secretary of Health and Human Services, all ex officio, and of two members of the public (both of whom may not be from the same political party), who shall be nominated by the President for a term of 4 years and subject to confirmation by the Senate. A member of the Board of Trustees serving as a member of the public and nominated and confirmed to fill a vacancy occurring during a term shall be nominated and confirmed only for the remainder of such term. An individual nominated and confirmed as a member of the public may serve in such position after the expiration of such member's term until the earlier of the time at which the member's successor takes office or the time at which a report of the Board is first issued under paragraph (2) after the expiration of the

member's term. The Secretary of the Treasury shall be the Managing Trustee of the Board of Trustees. The Board of Trustees shall meet not less frequently than once each calendar year. A person serving on the Board of Trustees shall not be considered to be a fiduciary and shall not be personally liable for actions taken in such capacity with respect to the Trust Fund.

''(2) DUTIES.—

''(A) IN GENERAL.—It shall be the duty of the Board of Trustees to do the following:

''(i) Hold the CLASS Independence Fund.

''(ii) Report to the Congress not later than the first day of April of each year on the operation and status of the CLASS Independence Fund during the preceding fiscal year and on its expected operation and status during the current fiscal year and the next 2 fiscal years.

''(iii) Report immediately to the Congress whenever the Board is of the opinion that the amount of the CLASS Independence Fund is not actuarially sound in re-

gards to the projections under section 3203(b)(1)(B)(i).

''(iv) Review the general policies followed in managing the CLASS Independence Fund, and recommend changes in such policies, including necessary changes in the provisions of law which govern the way in which the CLASS Independence Fund is to be managed.

''(B) REPORT.—The report provided for in subparagraph (A)(ii) shall—

''(i) include—

''(I) a statement of the assets of, and the disbursements made from, the CLASS Independence Fund during the preceding fiscal year;

''(II) an estimate of the expected income to, and disbursements to be made from, the CLASS Independence Fund during the current fiscal year and each of the next 2 fiscal years;

''(III) a statement of the actuarial status of the CLASS Independence Fund for the current fiscal year, each of the next 2 fiscal years, and as

projected over the 75-year period beginning with the current fiscal year; and

''(IV) an actuarial opinion certifying that the techniques and methodologies used are generally accepted within the actuarial profession and that the assumptions and cost estimates used are reasonable; and

''(ii) be printed as a House document of the session of the Congress to which the report is made.

''(C) RECOMMENDATIONS.—If the Board of Trustees determines that enrollment trends and expected future benefit claims on the CLASS Independence Fund are not actuarially sound in regards to the projections under section 3203(b)(1)(B)(i) and are unlikely to be resolved with reasonable premium increases or through other means, the Board of Trustees shall include in the report provided for in subparagraph (A)(ii) recommendations for such legislative action as the Board of Trustees determine to be appropriate, including whether to

adjust monthly premiums or impose a temporary moratorium on new enrollments.

"SEC. 3207. CLASS INDEPENDENCE ADVISORY COUNCIL.

''(a) ESTABLISHMENT.—There is hereby created an Advisory Committee to be known as the 'CLASS Independence Advisory Council'.

''(b) MEMBERSHIP.—

''(1) IN GENERAL.—The CLASS Independence Advisory Council shall be composed of not more than 15 individuals, not otherwise in the employ of the United States—

''(A) who shall be appointed by the President without regard to the civil service laws and regulations; and

''(B) a majority of whom shall be representatives of individuals who participate or are likely to participate in the CLASS program, and shall include representatives of older and younger workers, individuals with disabilities, family caregivers of individuals who require services and supports to maintain their independence at home or in another residential setting of their choice in the community, individuals with expertise in long-term care or disability insurance, actuarial science, economics,

and other relevant disciplines, as determined by the Secretary.

''(2) TERMS.—

''(A) IN GENERAL.—The members of the CLASS Independence Advisory Council shall serve overlapping terms of 3 years (unless appointed to fill a vacancy occurring prior to the expiration of a term, in which case the individual shall serve for the remainder of the term).

''(B) LIMITATION.—A member shall not be eligible to serve for more than 2 consecutive terms.

''(3) CHAIR.—The President shall, from time to time, appoint one of the members of the CLASS Independence Advisory Council to serve as the Chair.

''(c) DUTIES.—The CLASS Independence Advisory Council shall advise the Secretary on matters of general policy in the administration of the CLASS program established under this title and in the formulation of regulations under this title including with respect to—

''(1) the development of the CLASS Independence Benefit Plan under section 3203; and

''(2) the determination of monthly premiums under such plan.

''(d) APPLICATION OF FACA.—The Federal Advisory Committee Act, other than section 14 of that Act, shall apply to the CLASS Independence Advisory Council.

''(e) AUTHORIZATION OF APPROPRIATIONS.—

''(1) IN GENERAL.—There are authorized to be appropriated to the CLASS Independence Advisory Council to carry out its duties under this section, such sums as may be necessary for fiscal year 2011 and for each fiscal year thereafter.

''(2) AVAILABILITY.—Any sums appropriated under the authorization contained in this section shall remain available, without fiscal year limitation, until expended.

"SEC. 3208. REGULATIONS; ANNUAL REPORT.

''(a) REGULATIONS.—The Secretary shall promulgate such regulations as are necessary to carry out the CLASS program in accordance with this title. Such regulations shall include provisions to prevent fraud and abuse under the program.

''(b) ANNUAL REPORT.—Beginning January 1, 2014, the Secretary shall submit an annual report to Congress on the CLASS program. Each report shall include the following:

''(1) The total number of enrollees in the program.

''(2) The total number of eligible beneficiaries during the fiscal year.

''(3) The total amount of cash benefits provided during the fiscal year.

''(4) A description of instances of fraud or abuse identified during the fiscal year.

''(5) Recommendations for such administrative or legislative action as the Secretary determines is necessary to improve the program or to prevent the occurrence of fraud or abuse.

''SEC. 3209. INSPECTOR GENERAL'S REPORT.

''The Inspector General of the Department of Health and Human Services shall submit an annual report to the Secretary and Congress relating to the overall progress of the CLASS program and of the existence of waste, fraud, and abuse in the CLASS program. Each such report shall include findings in the following areas:

''(1) The eligibility determination process.

''(2) The provision of cash benefits.

''(3) Quality assurance and protection against waste, fraud, and abuse.

''(4) Recouping of unpaid and accrued benefits.''.

(b) CONFORMING AMENDMENTS TO MEDICAID.—For conforming provisions amending the Medicaid program, see section 1739.

Subtitle E—Miscellaneous

SEC. 2585. STATES FAILING TO ADHERE TO CERTAIN EMPLOYMENT OBLIGATIONS.

A State is eligible for Federal funds under the provisions of the Public Health Service Act (42 U.S.C. 201 et seq.) only if the State—

(1) agrees to be subject in its capacity as an employer to each obligation under division A of this Act and the amendments made by such division applicable to persons in their capacity as an employer; and

(2) assures that all political subdivisions in the State will do the same.

SEC. 2586. HEALTH CENTERS UNDER PUBLIC HEALTH SERVICE ACT; LIABILITY PROTECTIONS FOR VOLUNTEER PRACTITIONERS.

(a) IN GENERAL.—Section 224 (42 U.S.C. 233) is amended—

(1) in subsection (g)(1)(A)—

(A) in the first sentence, by striking ''or employee'' and inserting ''employee, or (subject

to subsection (k)(4)) volunteer practitioner''; and

(B) in the second sentence, by inserting ''and subsection (k)(4)'' after ''subject to paragraph (5)''; and

(2) in each of subsections (g), (i), (j), (l), and (m), by striking the term ''employee, or contractor'' each place such term appears and inserting ''employee, volunteer practitioner, or contractor'';

(3) in subsection (g)(1)(H), by striking the term ''employee, and contractor'' each place such term appears and inserting ''employee, volunteer practitioner, and contractor'';

(4) in subsection (l), by striking the term ''employee, or any contractor'' and inserting ''employee, volunteer practitioner, or contractor''; and

(5) in subsections (h)(3) and (k), by striking the term ''employees, or contractors'' each place such term appears and inserting ''employees, volunteer practitioners, or contractors''.

(b) APPLICABILITY; DEFINITION.—Section 224(k) (42 U.S.C. 233(k)) is amended by adding at the end the following paragraph:

''(4)(A) Subsections (g) through (m) apply with respect to volunteer practitioners beginning with the first

fiscal year for which an appropriations Act provides that amounts in the fund under paragraph (2) are available with respect to such practitioners.

''(B) For purposes of subsections (g) through (m), the term 'volunteer practitioner' means a practitioner who, with respect to an entity described in subsection (g)(4), meets the following conditions:

''(i) The practitioner is a licensed physician, a licensed clinical psychologist, or other licensed or certified health care practitioner.

''(ii) At the request of such entity, the practitioner provides services to patients of the entity, at a site at which the entity operates or at a site designated by the entity. The weekly number of hours of services provided to the patients by the practitioner is not a factor with respect to meeting conditions under this subparagraph.

''(iii) The practitioner does not for the provision of such services receive any compensation from such patients, from the entity, or from third-party payors (including reimbursement under any insurance policy or health plan, or under any Federal or State health benefits program).''.

SEC. 2587. REPORT TO CONGRESS ON THE CURRENT STATE OF PARASITIC DISEASES THAT HAVE BEEN OVERLOOKED AMONG THE POOREST AMERICANS.

Not later than 12 months after the date of the enactment of this Act, the Secretary of Health and Human Services shall report to Congress on the epidemiology of, impact of, and appropriate funding required to address neglected diseases of poverty, including neglected parasitic diseases identified as Chagas disease, cysticercosis, toxocariasis, toxoplasmosis, trichomoniasis, the soil-transmitted helminths, and others. The report should provide the information necessary to enhance health policy to accurately evaluate and address the threat of these diseases.

SEC. 2588. OFFICE OF WOMEN'S HEALTH.

(a) HEALTH AND HUMAN SERVICES OFFICE ON WOMEN'S HEALTH.—

(1) ESTABLISHMENT.—Part A of title II (42 U.S.C. 202 et seq.) is amended by adding at the end the following:

"SEC. 229. HEALTH AND HUMAN SERVICES OFFICE ON WOMEN'S HEALTH.

''(a) ESTABLISHMENT OF OFFICE.—There is established within the Office of the Secretary, an Office on Women's Health (referred to in this section as the 'Office'). The Office shall be headed by a Deputy Assistant

Secretary for Women's Health who may report to the Secretary.

''(b) DUTIES.—The Secretary, acting through the Office, with respect to the health concerns of women, shall—

''(1) establish short-range and long-range goals and objectives within the Department of Health and Human Services and, as relevant and appropriate, coordinate with other appropriate offices on activities within the Department that relate to disease prevention, health promotion, service delivery, research, and public and health care professional education, for issues of particular concern to women throughout their lifespan;

''(2) provide expert advice and consultation to the Secretary concerning scientific, legal, ethical, and policy issues relating to women's health;

''(3) monitor the Department of Health and Human Services' offices, agencies, and regional activities regarding women's health and identify needs regarding the coordination of activities, including intramural and extramural multidisciplinary activities;

''(4) establish a Department of Health and Human Services Coordinating Committee on Women's Health, which shall be chaired by the Deputy Assistant Secretary for Women's Health and com-

posed of senior level representatives from each of the agencies and offices of the Department of Health and Human Services;

''(5) establish a National Women's Health Information Center to—

''(A) facilitate the exchange of information regarding matters relating to health information, health promotion, preventive health services, research advances, and education in the appropriate use of health care;

''(B) facilitate access to such information;

''(C) assist in the analysis of issues and problems relating to the matters described in this paragraph; and

''(D) provide technical assistance with respect to the exchange of information (including facilitating the development of materials for such technical assistance);

''(6) coordinate efforts to promote women's health programs and policies with the private sector; and

''(7) through publications and any other means appropriate, provide for the exchange of information between the Office and recipients of grants, contracts, and agreements under subsection (c), and be-

tween the Office and health professionals and the general public.

''(c) GRANTS AND CONTRACTS REGARDING DUTIES.—

''(1) AUTHORITY.—In carrying out subsection (b), the Secretary may make grants to, and enter into cooperative agreements, contracts, and interagency agreements with, public and private entities, agencies, and organizations.

''(2) EVALUATION AND DISSEMINATION.—The Secretary shall directly or through contracts with public and private entities, agencies, and organizations, provide for evaluations of projects carried out with financial assistance provided under paragraph (1) and for the dissemination of information developed as a result of such projects.

''(d) REPORTS.—Not later than 1 year after the date of enactment of this section, and every second year thereafter, the Secretary shall prepare and submit to the appropriate committees of Congress a report describing the activities carried out under this section during the period for which the report is being prepared.''.

(2) TRANSFER OF FUNCTIONS.—There are transferred to the Office on Women's Health (established under section 229 of the Public Health Serv-

ice Act, as added by this section), all functions exercised by the Office on Women's Health of the Public Health Service prior to the date of enactment of this section, including all personnel and compensation authority, all delegation and assignment authority, and all remaining appropriations. All orders, determinations, rules, regulations, permits, agreements, grants, contracts, certificates, licenses, registrations, privileges, and other administrative actions that—

(A) have been issued, made, granted, or allowed to become effective by the President, any Federal agency or official thereof, or by a court of competent jurisdiction, in the performance of functions transferred under this paragraph; and

(B) are in effect at the time this section takes effect, or were final before the date of enactment of this section and are to become effective on or after such date;

shall continue in effect according to their terms until modified, terminated, superseded, set aside, or revoked in accordance with law by the President, the Secretary, or other authorized official, a court of competent jurisdiction, or by operation of law.

(b) CENTERS FOR DISEASE CONTROL AND PREVENTION OFFICE OF WOMEN'S HEALTH.—Part A of title III

(42 U.S.C. 241 et seq.) is amended by adding at the end the following:

"SEC. 310A. CENTERS FOR DISEASE CONTROL AND PREVENTION OFFICE OF WOMEN'S HEALTH.

''(a) ESTABLISHMENT.—There is established within the Office of the Director of the Centers for Disease Control and Prevention, an office to be known as the Office of Women's Health (referred to in this section as the 'Office'). The Office shall be headed by a director who shall be appointed by the Director of such Centers.

''(b) PURPOSE.—The Director of the Office shall—

''(1) report to the Director of the Centers for Disease Control and Prevention on the current level of the Centers' activity regarding women's health conditions across, where appropriate, age, biological, and sociocultural contexts, in all aspects of the Centers' work, including prevention programs, public and professional education, services, and treatment;

''(2) establish short-range and long-range goals and objectives within the Centers for women's health and, as relevant and appropriate, coordinate with other appropriate offices on activities within the Centers that relate to prevention, research, education and training, service delivery, and policy de-

velopment, for issues of particular concern to women;

''(3) identify projects in women's health that should be conducted or supported by the Centers;

''(4) consult with health professionals, non-governmental organizations, consumer organizations, women's health professionals, and other individuals and groups, as appropriate, on the policy of the Centers with regard to women; and

''(5) serve as a member of the Department of Health and Human Services Coordinating Committee on Women's Health (established under section 229(b)(4)).

''(c) DEFINITION.—As used in this section, the term 'women's health conditions', with respect to women of all age, ethnic, and racial groups, means diseases, disorders, and conditions—

''(1) unique to, significantly more serious for, or significantly more prevalent in women; and

''(2) for which the factors of medical risk or type of medical intervention are different for women, or for which there is reasonable evidence that indicates that such factors or types may be different for women.''.

(c) OFFICE OF WOMEN'S HEALTH RESEARCH.—Section 486(a) (42 U.S.C. 287d(a)) is amended by inserting ''and who shall report directly to the Director'' before the period at the end thereof.

(d) SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION.—Section 501(f) (42 U.S.C. 290aa(f)) is amended—

(1) in paragraph (1), by inserting ''who shall report directly to the Administrator'' before the period;

(2) by redesignating paragraph (4) as paragraph (5); and

(3) by inserting after paragraph (3), the following:

''(4) OFFICE.—Nothing in this subsection shall be construed to preclude the Secretary from establishing within the Substance Abuse and Mental Health Administration an Office of Women's Health.''.

(e) AGENCY FOR HEALTHCARE RESEARCH AND QUALITY ACTIVITIES REGARDING WOMEN'S HEALTH.—Part C of title IX (42 U.S.C. 299c et seq.) is amended—

(1) by redesignating sections 927 and 928 as sections 928 and 929, respectively;

(2) by inserting after section 926 the following:

"SEC. 927. ACTIVITIES REGARDING WOMEN'S HEALTH.

''(a) ESTABLISHMENT.—There is established within the Office of the Director, an Office of Women's Health and Gender-Based Research (referred to in this section as the 'Office'). The Office shall be headed by a director who shall be appointed by the Director of Healthcare and Research Quality.

''(b) PURPOSE.—The official designated under subsection (a) shall—

''(1) report to the Director on the current Agency level of activity regarding women's health, across, where appropriate, age, biological, and sociocultural contexts, in all aspects of Agency work, including the development of evidence reports and clinical practice protocols and the conduct of research into patient outcomes, delivery of health care services, quality of care, and access to health care;

''(2) establish short-range and long-range goals and objectives within the Agency for research important to women's health and, as relevant and appropriate, coordinate with other appropriate offices on activities within the Agency that relate to health services and medical effectiveness research, for issues of particular concern to women;

''(3) identify projects in women's health that should be conducted or supported by the Agency;

''(4) consult with health professionals, non-governmental organizations, consumer organizations, women's health professionals, and other individuals and groups, as appropriate, on Agency policy with regard to women; and

''(5) serve as a member of the Department of Health and Human Services Coordinating Committee on Women's Health (established under section 229(b)(4)).''; and

(3) by adding at the end of section 928 (as redesignated by paragraph (1)) the following:

''(e) WOMEN'S HEALTH.—For the purpose of carrying out section 927 regarding women's health, there are authorized to be appropriated such sums as may be necessary for each of fiscal years 2011 through 2015.''.

(f) HEALTH RESOURCES AND SERVICES ADMINISTRATION OFFICE OF WOMEN'S HEALTH.—Title VII of the Social Security Act (42 U.S.C. 901 et seq.) is amended by adding at the end the following:

''SEC. 713. OFFICE OF WOMEN'S HEALTH.

''(a) ESTABLISHMENT.—The Secretary shall establish within the Office of the Administrator of the Health Resources and Services Administration, an office to be known as the Office of Women's Health. The Office shall

be headed by a director who shall be appointed by the Administrator.

''(b) PURPOSE.—The Director of the Office shall—

''(1) report to the Administrator on the current Administration level of activity regarding women's health across, where appropriate, age, biological, and sociocultural contexts;

''(2) establish short-range and long-range goals and objectives within the Health Resources and Services Administration for women's health and, as relevant and appropriate, coordinate with other appropriate offices on activities within the Administration that relate to health care provider training, health service delivery, research, and demonstration projects, for issues of particular concern to women;

''(3) identify projects in women's health that should be conducted or supported by the bureaus of the Administration;

''(4) consult with health professionals, nongovernmental organizations, consumer organizations, women's health professionals, and other individuals and groups, as appropriate, on Administration policy with regard to women; and

''(5) serve as a member of the Department of Health and Human Services Coordinating Com-

mittee on Women's Health (established under section 229(b)(4) of the Public Health Service Act).

''(c) CONTINUED ADMINISTRATION OF EXISTING PROGRAMS.—The Director of the Office shall assume the authority for the development, implementation, administration, and evaluation of any projects carried out through the Health Resources and Services Administration relating to women's health on the date of enactment of this section.

''(d) DEFINITIONS.—For purposes of this section:

''(1) ADMINISTRATION.—The term 'Administration' means the Health Resources and Services Administration.

''(2) ADMINISTRATOR.—The term 'Administrator' means the Administrator of the Health Resources and Services Administration.

''(3) OFFICE.—The term 'Office' means the Office of Women's Health established under this section in the Administration.''.

(g) FOOD AND DRUG ADMINISTRATION OFFICE OF WOMEN'S HEALTH.—Chapter IX of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 391 et seq.) is amended by adding at the end the following:

"SEC. 911. OFFICE OF WOMEN'S HEALTH.

''(a) ESTABLISHMENT.—There is established within the Office of the Commissioner, an office to be known as the Office of Women's Health (referred to in this section as the 'Office'). The Office shall be headed by a director who shall be appointed by the Commissioner of Food and Drugs.

''(b) PURPOSE.—The Director of the Office shall—

''(1) report to the Commissioner of Food and Drugs on current Food and Drug Administration (referred to in this section as the 'Administration') levels of activity regarding women's participation in clinical trials and the analysis of data by sex in the testing of drugs, medical devices, and biological products across, where appropriate, age, biological, and sociocultural contexts;

''(2) establish short-range and long-range goals and objectives within the Administration for issues of particular concern to women's health within the jurisdiction of the Administration, including, where relevant and appropriate, adequate inclusion of women and analysis of data by sex in Administration protocols and policies;

''(3) provide information to women and health care providers on those areas in which differences between men and women exist;

''(4) consult with pharmaceutical, biologics, and device manufacturers, health professionals with expertise in women's issues, consumer organizations, and women's health professionals on Administration policy with regard to women;

''(5) make annual estimates of funds needed to monitor clinical trials and analysis of data by sex in accordance with needs that are identified; and

''(6) serve as a member of the Department of Health and Human Services Coordinating Committee on Women's Health (established under section 229(b)(4) of the Public Health Service Act).''.

(h) NO NEW REGULATORY AUTHORITY.—Nothing in this section and the amendments made by this section may be construed as establishing regulatory authority or modifying any existing regulatory authority.

(i) LIMITATION ON TERMINATION.—Notwithstanding any other provision of law, a Federal office of women's health (including the Office of Research on Women's Health of the National Institutes of Health) or Federal appointive position with primary responsibility over women's health issues (including the Associate Administrator for Women's Services under the Substance Abuse and Mental Health Services Administration) that is in existence on the date of enactment of this section shall not

be terminated, reorganized, or have any of its powers or duties transferred unless such termination, reorganization, or transfer is approved by an Act of Congress.

(j) RULE OF CONSTRUCTION.—Nothing in this section (or the amendments made by this section) shall be construed to limit the authority of the Secretary of Health and Human Services with respect to women's health, or with respect to activities carried out through the Department of Health and Human Services on the date of enactment of this section.

SEC. 2589. LONG-TERM CARE AND FAMILY CAREGIVER SUPPORT.

(a) AMENDMENTS TO THE OLDER AMERICANS ACT OF 1965.—

(1) PROMOTION OF DIRECT CARE WORKFORCE.—Section 202(b)(1) of the Older Americans Act of 1965 (42 U.S.C. 3012(b)(1)) is amended by inserting before the semicolon the following: ", and, in carrying out the purposes of this paragraph, shall make recommendations to other Federal entities regarding appropriate and effective means of identifying, promoting, and implementing investments in the direct care workforce necessary to meet the growing demand for long-term health services and supports and of assisting States in developing a

comprehensive State workforce development plan with respect to such workforce, including assisting efforts to systematically assess, track, and report on workforce adequacy and capacity''.

(2) PERSONAL CARE ATTENDANT WORKFORCE ADVISORY PANEL.—Section 202 of such Act (42 U.S.C. 3012) is amended by adding at the end the following:

''(g)(1) Not later than 90 days after the date of the enactment of this subsection, the Assistant Secretary shall establish a Personal Care Attendant Workforce Advisory Panel to examine and formulate recommendations on—

''(A) working conditions and training for workers providing long-term services and supports, including home health aides, certified nurse aides, and personal care attendants; and

''(B) other workforce issues related to such workers, including with respect to the adequacy of the number of such workers; the salaries, wages, and benefits of such workers; and access to the services provided by such workers.

''(2) The Panel shall include representatives of—

''(A) relevant home- and community-based service providers, health care agencies, and facilities (including personal or home care agencies, home health

care agencies, nursing homes, assisted living facilities, and residential care facilities);

''(B) the disability community, including individuals with disabilities and family caregivers;

''(C) the nursing community;

''(D) direct care workers (which may include unions and national organizations);

''(E) older individuals, including senior individuals and family caregivers;

''(F) State and Federal health care entities; and

''(G) experts in workforce development and adult learning.

''(3) Within one year after the establishment of the Panel, the Panel shall submit a report to the Assistant Secretary and the Congress on workforce issues related to providing long-term services and supports, including information on core competencies for eligible personal or home care aides necessary to successfully provide long-term services and supports to eligible consumers, as well as recommended training curricula and resources.

''(4) Within 180 days after receipt by the Assistant Secretary of the report under paragraph (3), the Assistant Secretary shall establish a 3-year demonstration program in 4 States to pilot and evaluate the effectiveness of the

competencies articulated by the Panel and the training curricula and training methods recommended by the Panel.

''(5) Not later than 1 year after the completion of the demonstration program under paragraph (4), the Assistant Secretary shall submit to the Congress a report containing the results of the evaluations by the Assistant Secretary pursuant to paragraph (4), together with such recommendations for legislation or administrative action as the Assistant Secretary determines appropriate.''.

(b) AUTHORIZATION OF ADDITIONAL APPROPRIATIONS FOR THE FAMILY CAREGIVER SUPPORT PROGRAM UNDER THE OLDER AMERICANS ACT OF 1965.—Section 303(e)(2) of the Older Americans Act of 1965 (42 U.S.C. 3023(e)(2)) is amended by striking '', $173,000,000'' and all that follows through ''2011'', and inserting ''and $250,000,000 for each of fiscal years 2011, 2012, and 2013''.

SEC. 2590. WEB SITE ON HEALTH CARE LABOR MARKET AND RELATED EDUCATIONAL AND TRAINING OPPORTUNITIES.

(a) IN GENERAL.—The Secretary of Labor, in consultation with the National Center for Health Workforce Analysis, shall establish and maintain a Web site to serve as a comprehensive source of information, searchable by

workforce region, on the health care labor market and related educational and training opportunities.

(b) CONTENTS.—The Web site maintained under this section shall include the following:

(1) Information on the types of jobs that are currently or are projected to be in high demand in the health care field, including—

(A) salary information; and

(B) training requirements, such as requirements for educational credentials, licensure, or certification.

(2) Information on training and educational opportunities within each region for the type of jobs described in paragraph (1), including by—

(A) type of provider or program (such as public, private nonprofit, or private for-profit);

(B) duration;

(C) cost (such as tuition, fees, books, laboratory expenses, and other mandatory costs);

(D) performance outcomes (such as graduation rates, job placement, average salary, job retention, and wage progression);

(E) Federal financial aid participation;

(F) average graduate loan debt;

(G) student loan default rates;

(H) average institutional grant aid provided;

(I) Federal and State accreditation information; and

(J) other information determined by the Secretary.

(3) A mechanism for searching and comparing training and educational options for specific health care occupations to facilitate informed career and education choices.

(4) Financial aid information, including with respect to loan forgiveness, loan cancellation, loan repayment, stipends, scholarships, and grants or other assistance authorized by this Act or other Federal or State programs.

(c) PUBLIC ACCESSIBILITY.—The Web site maintained under this section shall—

(1) be publicly accessible;

(2) be user friendly and convey information in a manner that is easily understandable; and

(3) be in English and the second most prevalent language spoken based on the latest Census information.

SEC. 2591. ONLINE HEALTH WORKFORCE TRAINING PROGRAMS.

Section 171 of the Workforce Investment Act of 1998 (29 U.S.C. 2916) is amended by adding at the end the following:

''(f) ONLINE HEALTH WORKFORCE TRAINING PROGRAM.—

''(1) GRANT PROGRAM.—

''(A) IN GENERAL.—The Secretary in consultation with the Secretary of Health and Human Services, shall award National Health Workforce Online Training Grants on a competitive basis to eligible entities to enable such entities to carry out training for individuals to attain or advance in health care occupations. An entity may leverage such grant with other Federal, State, local, and private resources, in order to expand the participation of businesses, employees, and individuals in such training programs.

''(B) ELIGIBILITY.—In order to receive a grant under the program established under this paragraph—

''(i) an entity shall be an educational institution, community-based organization, nonprofit organization, workforce invest-

ment board, or local or county government; and

''(ii) an entity shall provide online workforce training for individuals seeking to attain or advance in health care occupations, including nursing, nursing assistants, dentistry, pharmacy, health care management and administration, public health, health information systems analysis, medical assistants, and other health care practitioner and support occupations.

''(C) PRIORITY.—Priority in awarding grants under this paragraph shall be given to entities that—

''(i) have demonstrated experience in implementing and operating online worker skills training and education programs;

''(ii) have demonstrated experience coordinating activities, where appropriate, with the workforce investment system; and

''(iii) conduct training for occupations with national or local shortages.

''(D) DATA COLLECTION.—Grantees under this paragraph shall collect and report information on—

''(i) the number of participants;

''(ii) the services received by the participants;

''(iii) program completion rates;

''(iv) factors determined as significantly interfering with program participation or completion;

''(v) the rate of job placement; and

''(vi) other information as determined as needed by the Secretary.

''(E) OUTREACH.—Grantees under this paragraph shall conduct outreach activities to disseminate information about their program and results to workforce investment boards, local governments, educational institutions, and other workforce training organizations.

''(F) PERFORMANCE LEVELS.—The Secretary shall establish indicators of performance that will be used to evaluate the performance of grantees under this paragraph in carrying out the activities described in this paragraph. The Secretary shall negotiate and reach agreement with each grantee regarding the levels of performance expected to be achieved by the grantee on the indicators of performance.

''(G) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to the Secretary to carry out this subsection $50,000,000 for fiscal years 2011 through 2020.

''(2) ONLINE HEALTH PROFESSIONS TRAINING PROGRAM CLEARINGHOUSE.—

''(A) DESCRIPTION OF GRANT.—The Secretary may award one or more grants to eligible postsecondary educational institutions to provide the services described in this paragraph.

''(B) ELIGIBILITY.—To be eligible to receive a grant under this paragraph, a postsecondary educational institution shall—

''(i) have demonstrated the ability to disseminate research on best practices for implementing workforce investment programs; and

''(ii) be a national leader in producing cutting-edge research on technology related to workforce investment systems under subtitle B.

''(C) SERVICES.—The postsecondary educational institution that receives a grant under this paragraph shall use such grant—

''(i) to provide technical assistance to entities that receive grants under paragraph (1);

''(ii) to collect and nationally disseminate the data gathered by entities that receive grants under paragraph (1); and

''(iii) to disseminate the best practices identified by the National Health Workforce Online Training Grant Program to other workforce training organizations.

''(D) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to the Secretary to carry out this subsection $1,000,000 for fiscal years 2011 through 2020.''.

SEC. 2592. ACCESS FOR INDIVIDUALS WITH DISABILITIES.

Title V of the Rehabilitation Act of 1973 (29 U.S.C. 791 et seq.) is amended by adding at the end of the following:

''SEC. 510. STANDARDS FOR ACCESSIBILITY OF MEDICAL DIAGNOSTIC EQUIPMENT.

''(a) STANDARDS.—Not later than 9 months after the date of enactment of the Affordable Health Care for America Act, the Architectural and Transportation Barriers Compliance Board (Access Board) shall issue guide-

lines setting forth the minimum technical criteria for new medical diagnostic equipment to be purchased for use in (or in conjunction with) physician's offices, clinics, emergency rooms, hospitals, and other medical settings. The guidelines shall ensure that such equipment is accessible to, and usable by, individuals with disabilities, including provisions to ensure independent entry to, use of, and exit from the equipment by such individuals to the maximum extent possible.

''(b) MEDICAL DIAGNOSTIC EQUIPMENT COVERED.—The guidelines issued under subsection (a) for medical diagnostic equipment shall apply to new purchases of equipment that includes examination tables, examination chairs (including chairs used for eye examinations or procedures, and dental examinations or procedures), weight scales, mammography equipment, x-ray machines, and other equipment commonly used for diagnostic or examination purposes by health professionals.

''(c) REGULATIONS.—Not later than 6 months after the date of the issuance of the guidelines under subsection (a), each appropriate Federal agency authorized to promulgate regulations under this Act or under the Americans with Disabilities Act shall—

''(1) prescribe regulations in an accessible format as necessary to carry out the provisions of such

Act and section 504 of this Act that include accessibility standards that are consistent with the guidelines issued under subsection (a); and

''(2) ensure that health care providers and health care plans covered by the Affordable Health Care for America Act meet the requirements of the Americans with Disabilities Act and section 504, including provisions ensuring that individuals with disabilities receive equal access to all aspects of the health care delivery system.

''(d) REVIEW AND AMEND.—The Architectural and Transportation Barriers Compliance Board (Access Board) shall periodically review and, as appropriate, amend the guidelines as prescribed under subsection (a). Not later than 6 months after the date of the issuance of such revised guidelines, revised regulations consistent with such guidelines shall be promulgated in an accessible format by the appropriate Federal agencies described in subsection (c).''.

DIVISION D—INDIAN HEALTH CARE IMPROVEMENT

SEC. 3001. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This division may be cited as the ''Indian Health Care Improvement Act Amendments of 2009''.

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

TITLE I—AMENDMENTS TO INDIAN LAWS

SEC. 3101. INDIAN HEALTH CARE IMPROVEMENT AMENDED.

(a) IN GENERAL.—The Indian Health Care Improvement Act (25 U.S.C. 1601 et seq.) is amended to read as follows:

"SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

"(a) SHORT TITLE.—This Act may be cited as the 'Indian Health Care Improvement Act'.

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

''SEC. 2. FINDINGS.

''Congress makes the following findings:

''(1) Federal health services to maintain and improve the health of the Indians are consonant with and required by the Federal Government's historical and unique legal relationship with, and resulting responsibility to, the American Indian people.

''(2) A major national goal of the United States is to provide the resources, processes, and structure that will enable Indian tribes and tribal members to obtain the quantity and quality of health care serv-

ices and opportunities that will eradicate the health disparities between Indians the general population.

''(3) A major national goal of the United States is to provide the quantity and quality of health services which will permit the health status of Indians to be raised to the highest possible level and to encourage the maximum participation of Indians in the planning and management of those services.

''(4) Federal health services to Indians have resulted in a reduction in the prevalence and incidence of preventable illnesses among, and unnecessary and premature deaths of, Indians.

''(5) Despite such services, the unmet health needs of the American Indian people are severe and the health status of the Indians is far below that of the general population of the United States.

''SEC. 3. DECLARATION OF NATIONAL INDIAN HEALTH POLICY.

''Congress declares that it is the policy of this Nation, in fulfillment of its special trust responsibilities and legal obligations to Indians—

''(1) to assure the highest possible health status for Indians and Urban Indians and to provide all resources necessary to effect that policy;

''(2) to raise the health status of Indians and Urban Indians to at least the levels set forth in the goals contained within the Health People 2010 or successor objectives;

''(3) to the greatest extent possible, to allow Indians to set their own health care priorities and establish goals that reflect their unmet needs;

''(4) to increase the proportion of all degrees in the health professions and allied and associated health professions awarded to Indians so that the proportion of Indian health professionals in each Service Area is raised to at least the level of that of the general population;

''(5) to require meaningful consultation with Indian Tribes, Tribal Organizations, and urban Indian organizations to implement this Act and the national policy of Indian self-determination; and

''(6) to provide funding for programs and facilities operated by Indian Tribes, Tribal Organizations, and Urban Indian Organizations in amounts that are not less than the amounts provided to programs and facilities operated directly by the Service.

''SEC. 4. DEFINITIONS.

''For purposes of this Act:

''(1) The term 'accredited and accessible' means on or near a reservation and accredited by a national or regional organization with accrediting authority.

''(2) The term 'Area Office' means an administrative entity, including a program office, within the Service through which services and funds are provided to the Service Units within a defined geographic area.

''(3) The term 'Assistant Secretary' means the Assistant Secretary of Indian Health.

''(4)(A) The term 'behavioral health' means the blending of substance (including alcohol, drugs, inhalants, and tobacco) abuse and mental health prevention and treatment, for the purpose of providing comprehensive services.

''(B) The term 'behavioral health' includes the joint development of substance abuse and mental health treatment planning and coordinated case management using a multidisciplinary approach.

''(5) The term 'California Indians' means those Indians who are eligible for health services of the Service pursuant to section 805.

''(6) The term 'community college' means—

''(A) a tribal college or university, or

''(B) a junior or community college.

''(7) The term 'contract health service' means health services provided at the expense of the Service or a Tribal Health Program by public or private medical providers or hospitals, other than the Service Unit or the Tribal Health Program at whose expense the services are provided.

''(8) The term 'Department' means, unless otherwise designated, the Department of Health and Human Services.

''(9) The term 'disease prevention' means the reduction, limitation, and prevention of disease and its complications and reduction in the consequences of disease, including—

''(A) controlling—

''(i) the development of diabetes;

''(ii) high blood pressure;

''(iii) infectious agents;

''(iv) injuries;

''(v) occupational hazards and disabilities;

''(vi) sexually transmittable diseases; and

''(vii) toxic agents; and

''(B) providing—

''(i) fluoridation of water; and

''(ii) immunizations.

''(10) The term 'health profession' means allopathic medicine, family medicine, internal medicine, pediatrics, geriatric medicine, obstetrics and gynecology, podiatric medicine, nursing, public health nursing, dentistry, psychiatry, osteopathy, optometry, pharmacy, psychology, public health, social work, marriage and family therapy, chiropractic medicine, environmental health and engineering, allied health professions, naturopathic medicine, and any other health profession.

''(11) The term 'health promotion' means—

''(A) fostering social, economic, environmental, and personal factors conducive to health, including raising public awareness about health matters and enabling the people to cope with health problems by increasing their knowledge and providing them with valid information;

''(B) encouraging adequate and appropriate diet, exercise, and sleep;

''(C) promoting education and work in conformity with physical and mental capacity;

''(D) making available safe water and sanitary facilities;

''(E) improving the physical, economic, cultural, psychological, and social environment;

''(F) promoting culturally competent care; and

''(G) providing adequate and appropriate programs, which may include—

''(i) abuse prevention (mental and physical);

''(ii) community health;

''(iii) community safety;

''(iv) consumer health education;

''(v) diet and nutrition;

''(vi) immunization and other prevention of communicable diseases, including HIV/AIDS;

''(vii) environmental health;

''(viii) exercise and physical fitness;

''(ix) avoidance of fetal alcohol disorders;

''(x) first aid and CPR education;

''(xi) human growth and development;

''(xii) injury prevention and personal safety;

''(xiii) behavioral health;

‘‘(xiv) monitoring of disease indicators between health care provider visits, through appropriate means, including Internet-based health care management systems;

‘‘(xv) personal health and wellness practices;

‘‘(xvi) personal capacity building;

‘‘(xvii) prenatal, pregnancy, and infant care;

‘‘(xviii) psychological well-being;

‘‘(xix) reproductive health and family planning;

‘‘(xx) safe and adequate water;

‘‘(xxi) healthy work environments;

‘‘(xxii) elimination, reduction, and prevention of contaminants that create unhealthy household conditions (including mold and other allergens);

‘‘(xxiii) stress control;

‘‘(xxiv) substance abuse;

‘‘(xxv) sanitary facilities;

‘‘(xxvi) sudden infant death syndrome prevention;

''(xxvii) tobacco use cessation and reduction;

''(xxviii) violence prevention; and

''(xxix) activities to promote achievement of any of the objectives described in section 3(2).

''(12) The term 'Indian', unless otherwise designated, means any person who is a member of an Indian Tribe or is eligible for health services under section 805, except that, for the purpose of sections 102 and 103, the term also means any individual who—

''(A)(i) irrespective of whether the individual lives on or near a reservation, is a member of a tribe, band, or other organized group of Indians, including those tribes, bands, or groups terminated since 1940 and those recognized now or in the future by the State in which they reside; or

''(ii) is a descendant, in the first or second degree, of any such member;

''(B) is an Eskimo or Aleut or other Alaska Native;

''(C) is considered by the Secretary of the Interior to be an Indian for any purpose; or

''(D) is determined to be an Indian under regulations promulgated by the Secretary.

''(13) The term 'Indian Health Program' means—

''(A) any health program administered directly by the Service;

''(B) any Tribal Health Program; or

''(C) any Indian Tribe or Tribal Organization to which the Secretary provides funding pursuant to section 23 of the Act of June 25, 1910 (25 U.S.C. 47) (commonly known as the 'Buy Indian Act').

''(14) The term 'Indian Tribe' has the meaning given the term in the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.).

''(15) The term 'junior or community college' has the meaning given the term by section 312(f) of the Higher Education Act of 1965 (20 U.S.C. 1058(f)).

''(16) The term 'reservation' means any federally recognized Indian Tribe's reservation, Pueblo, or colony, including former reservations in Oklahoma, Indian allotments, and Alaska Native Regions established pursuant to the Alaska Native Claims Settlement Act (43 U.S.C. 1601 et seq.).

''(17) The term 'Secretary', unless otherwise designated, means the Secretary of Health and Human Services.

''(18) The term 'Service' means the Indian Health Service.

''(19) The term 'Service Area' means the geographical area served by each Area Office.

''(20) The term 'Service Unit' means an administrative entity of the Service, or a Tribal Health Program through which services are provided, directly or by contract, to eligible Indians within a defined geographic area.

''(21) The term 'telehealth' has the meaning given the term in section 330K(a) of the Public Health Service Act (42 U.S.C. 254c–16(a)).

''(22) The term 'telemedicine' means a telecommunications link to an end user through the use of eligible equipment that electronically links health professionals or patients and health professionals at separate sites in order to exchange health care information in audio, video, graphic, or other format for the purpose of providing improved health care services.

''(23) The term 'tribal college or university' has the meaning given the term in section 316(b)(3) of the Higher Education Act (20 U.S.C. 1059c(b)(3)).

''(24) The term 'Tribal Health Program' means an Indian Tribe or Tribal Organization that operates any health program, service, function, activity, or facility funded, in whole or part, by the Service through, or provided for in, a contract or compact with the Service under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.).

''(25) The term 'Tribal Organization' has the meaning given the term in the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.).

''(26) The term 'Urban Center' means any community which has a sufficient Urban Indian population with unmet health needs to warrant assistance under title V of this Act, as determined by the Secretary.

''(27) The term 'Urban Indian' means any individual who resides in an Urban Center and who meets 1 or more of the following criteria:

''(A) Irrespective of whether the individual lives on or near a reservation, the individual is

a member of a tribe, band, or other organized group of Indians, including those tribes, bands, or groups terminated since 1940 and those tribes, bands, or groups that are recognized by the States in which they reside, or who is a descendant in the first or second degree of any such member.

''(B) The individual is an Eskimo, Aleut, or other Alaska Native.

''(C) The individual is considered by the Secretary of the Interior to be an Indian for any purpose.

''(D) The individual is determined to be an Indian under regulations promulgated by the Secretary.

''(28) The term 'urban Indian organization' means a nonprofit corporate body that (A) is situated in an Urban Center; (B) is governed by an Urban Indian-controlled board of directors; (C) provides for the participation of all interested Indian groups and individuals; and (D) is capable of legally cooperating with other public and private entities for the purpose of performing the activities described in section 503(a).

"TITLE I—INDIAN HEALTH, HUMAN RESOURCES, AND DEVELOPMENT

"SEC. 101. PURPOSE.

''The purpose of this title is to increase, to the maximum extent feasible, the number of Indians entering the health professions and providing health services, and to assure an optimum supply of health professionals to the Indian Health Programs and urban Indian organizations involved in the provision of health services to Indians.

"SEC. 102. HEALTH PROFESSIONS RECRUITMENT PROGRAM FOR INDIANS.

''(a) IN GENERAL.—The Secretary, acting through the Service, shall make grants to public or nonprofit private health or educational entities, Tribal Health Programs, or urban Indian organizations to assist such entities in meeting the costs of—

''(1) identifying Indians with a potential for education or training in the health professions and encouraging and assisting them—

''(A) to enroll in courses of study in such health professions; or

''(B) if they are not qualified to enroll in any such courses of study, to undertake such

postsecondary education or training as may be required to qualify them for enrollment;

''(2) publicizing existing sources of financial aid available to Indians enrolled in any course of study referred to in paragraph (1) or who are undertaking training necessary to qualify them to enroll in any such course of study; or

''(3) establishing other programs which the Secretary determines will enhance and facilitate the enrollment of Indians in, and the subsequent pursuit and completion by them of, courses of study referred to in paragraph (1).

''(b) GRANTS.—

''(1) APPLICATION.—No grant may be made under this section unless an application has been submitted to, and approved by, the Secretary. Such application shall be in such form, submitted in such manner, and contain such information, as the Secretary shall by regulation prescribe pursuant to this Act. The Secretary shall give a preference to applications submitted by Tribal Health Programs or urban Indian organizations.

''(2) AMOUNT OF GRANTS; PAYMENT.—The amount of a grant under this section shall be determined by the Secretary. Payments pursuant to this

section may be made in advance or by way of reimbursement, and at such intervals and on such conditions as provided for in regulations issued pursuant to this Act. To the extent not otherwise prohibited by law, grants shall be for 3 years, as provided in regulations issued pursuant to this Act.

"SEC. 103. HEALTH PROFESSIONS PREPARATORY SCHOLARSHIP PROGRAM FOR INDIANS.

''(a) SCHOLARSHIPS AUTHORIZED.—The Secretary, acting through the Service, shall provide scholarship grants to Indians who—

''(1) have successfully completed their high school education or high school equivalency; and

''(2) have demonstrated the potential to successfully complete courses of study in the health professions.

''(b) PURPOSES.—Scholarship grants provided pursuant to this section shall be for the following purposes:

''(1) Compensatory preprofessional education of any recipient, such scholarship not to exceed 2 years on a full-time basis (or the part-time equivalent thereof, as determined by the Secretary pursuant to regulations issued under this Act).

''(2) Pregraduate education of any recipient leading to a baccalaureate degree in an approved

course of study preparatory to a field of study in a health profession, such scholarship not to exceed 4 years. An extension of up to 2 years (or the part-time equivalent thereof, as determined by the Secretary pursuant to regulations issued pursuant to this Act) may be approved.

''(c) OTHER CONDITIONS.—Scholarships under this section—

''(1) may cover costs of tuition, books, transportation, board, and other necessary related expenses of a recipient while attending school;

''(2) shall not be denied solely on the basis of the applicant's scholastic achievement if such applicant has been admitted to, or maintained good standing at, an accredited institution; and

''(3) shall not be denied solely by reason of such applicant's eligibility for assistance or benefits under any other Federal program.

''SEC. 104. INDIAN HEALTH PROFESSIONS SCHOLARSHIPS.

''(a) IN GENERAL.—

''(1) AUTHORITY.—The Secretary, acting through the Service, shall make scholarship grants to Indians who are enrolled full or part time in accredited schools pursuing courses of study in the health professions. Such scholarships shall be des-

ignated Indian Health Scholarships and shall be made in accordance with section 338A of the Public Health Services Act (42 U.S.C. 254*l*), except as provided in subsection (b) of this section.

''(2) DETERMINATIONS BY SECRETARY.—The Secretary, acting through the Service, shall determine—

''(A) who shall receive scholarship grants under subsection (a); and

''(B) the distribution of the scholarships among health professions on the basis of the relative needs of Indians for additional service in the health professions.

''(3) CERTAIN DELEGATION NOT ALLOWED.—The administration of this section shall be a responsibility of the Assistant Secretary and shall not be delegated in a contract or compact under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.).

''(b) ACTIVE DUTY SERVICE OBLIGATION.—

''(1) OBLIGATION MET.—The active duty service obligation under a written contract with the Secretary under this section that an Indian has entered into shall, if that individual is a recipient of an Indian Health Scholarship, be met in full-time practice

equal to 1 year for each school year for which the participant receives a scholarship award under this part, or 2 years, whichever is greater, by service in 1 or more of the following:

''(A) In an Indian Health Program.

''(B) In a program assisted under title V of this Act.

''(C) In the private practice of the applicable profession if, as determined by the Secretary, in accordance with guidelines promulgated by the Secretary, such practice is situated in a physician or other health professional shortage area and addresses the health care needs of a substantial number of Indians.

''(D) In a teaching capacity in a tribal college or university nursing program (or a related health profession program) if, as determined by the Secretary, the health service provided to Indians would not decrease.

''(2) OBLIGATION DEFERRED.—At the request of any individual who has entered into a contract referred to in paragraph (1) and who receives a health professions degree requiring postgraduate training for licensure or to improve clinical skills, the Secretary shall defer the active duty service obligation

of that individual under that contract, in order that such individual may complete any internship, residency, or other advanced clinical training that is required for the practice of that health profession, for an appropriate period (in years, as determined by the Secretary), subject to the following conditions:

''(A) No period of internship, residency, or other advanced clinical training shall be counted as satisfying any period of obligated service under this subsection.

''(B) The active duty service obligation of that individual shall commence not later than 90 days after the completion of that advanced clinical training (or by a date specified by the Secretary).

''(C) The active duty service obligation will be served in the health profession of that individual in a manner consistent with paragraph (1).

''(D) A recipient of a scholarship under this section may, at the election of the recipient, meet the active duty service obligation described in paragraph (1) by service in a program specified under that paragraph that—

''(i) is located on the reservation of the Indian Tribe in which the recipient is enrolled; or

''(ii) serves the Indian Tribe in which the recipient is enrolled.

''(3) PRIORITY WHEN MAKING ASSIGNMENTS.—Subject to paragraph (2), the Secretary, in making assignments of Indian Health Scholarship recipients required to meet the active duty service obligation described in paragraph (1), shall give priority to assigning individuals to service in those programs specified in paragraph (1) that have a need for health professionals to provide health care services as a result of individuals having breached contracts entered into under this section.

''(c) PART-TIME STUDENTS.—In the case of an individual receiving a scholarship under this section who is enrolled part time in an approved course of study—

''(1) such scholarship shall be for a period of years not to exceed the part-time equivalent of 4 years, as determined by the Secretary;

''(2) the period of obligated service described in subsection (b)(1) shall be equal to the greater of—

''(A) the part-time equivalent of 1 year for each year for which the individual was provided

a scholarship (as determined by the Secretary); or

''(B) 2 years; and

''(3) the amount of the monthly stipend specified in section 338A(g)(1)(B) of the Public Health Service Act (42 U.S.C. 254*l*(g)(1)(B)) shall be reduced pro rata (as determined by the Secretary) based on the number of hours such student is enrolled.

''(d) BREACH OF CONTRACT.—

''(1) SPECIFIED BREACHES.—An individual shall be liable to the United States for the amount which has been paid to the individual, or on behalf of the individual, under a contract entered into with the Secretary under this section on or after the date of enactment of the Indian Health Care Improvement Act Amendments of 2009 if that individual—

''(A) fails to maintain an acceptable level of academic standing in the educational institution in which he or she is enrolled (such level determined by the educational institution under regulations of the Secretary);

''(B) is dismissed from such educational institution for disciplinary reasons;

''(C) voluntarily terminates the training in such an educational institution for which he or she is provided a scholarship under such contract before the completion of such training; or

''(D) fails to accept payment, or instructs the educational institution in which he or she is enrolled not to accept payment, in whole or in part, of a scholarship under such contract, in lieu of any service obligation arising under such contract.

''(2) OTHER BREACHES.—If for any reason not specified in paragraph (1) an individual breaches a written contract by failing either to begin such individual's service obligation required under such contract or to complete such service obligation, the United States shall be entitled to recover from the individual an amount determined in accordance with the formula specified in subsection (l) of section 110 in the manner provided for in such subsection.

''(3) CANCELLATION UPON DEATH OF RECIPIENT.—Upon the death of an individual who receives an Indian Health Scholarship, any outstanding obligation of that individual for service or payment that relates to that scholarship shall be canceled.

''(4) WAIVERS AND SUSPENSIONS.—The Secretary shall provide for the partial or total waiver or suspension of any obligation of service or payment of a recipient of an Indian Health Scholarship if the Secretary determines that—

''(A) it is not possible for the recipient to meet that obligation or make that payment;

''(B) requiring that recipient to meet that obligation or make that payment would result in extreme hardship to the recipient; or

''(C) the enforcement of the requirement to meet the obligation or make the payment would be unconscionable.

''(5) EXTREME HARDSHIP.—Notwithstanding any other provision of law, in any case of extreme hardship or for other good cause shown, the Secretary may waive, in whole or in part, the right of the United States to recover funds made available under this section.

''(6) BANKRUPTCY.—Notwithstanding any other provision of law, with respect to a recipient of an Indian Health Scholarship, no obligation for payment may be released by a discharge in bankruptcy under title 11, United States Code, unless that discharge is granted after the expiration of the 5-year

period beginning on the initial date on which that payment is due, and only if the bankruptcy court finds that the nondischarge of the obligation would be unconscionable.

"SEC. 105. AMERICAN INDIANS INTO PSYCHOLOGY PROGRAM.

''(a) GRANTS AUTHORIZED.—The Secretary, acting through the Service, shall make grants of not more than $300,000 to each of 9 colleges and universities for the purpose of developing and maintaining Indian psychology career recruitment programs as a means of encouraging Indians to enter the behavioral health field. These programs shall be located at various locations throughout the country to maximize their availability to Indian students and new programs shall be established in different locations from time to time.

''(b) QUENTIN N. BURDICK PROGRAM GRANT.—The Secretary shall provide a grant authorized under subsection (a) to develop and maintain a program at the University of North Dakota to be known as the 'Quentin N. Burdick American Indians Into Psychology Program'. Such program shall, to the maximum extent feasible, coordinate with the Quentin N. Burdick Indian Health Programs authorized under section 117(b), the Quentin N. Burdick American Indians Into Nursing Program author-

ized under section 115(e), and existing university research and communications networks.

''(c) REGULATIONS.—The Secretary shall issue regulations pursuant to this Act for the competitive awarding of grants provided under this section.

''(d) CONDITIONS OF GRANT.—Applicants under this section shall agree to provide a program which, at a minimum—

''(1) provides outreach and recruitment for health professions to Indian communities including elementary, secondary, and accredited and accessible community colleges that will be served by the program;

''(2) incorporates a program advisory board comprised of representatives from the tribes and communities that will be served by the program;

''(3) provides summer enrichment programs to expose Indian students to the various fields of psychology through research, clinical, and experimental activities;

''(4) provides stipends to undergraduate and graduate students to pursue a career in psychology;

''(5) develops affiliation agreements with tribal colleges and universities, the Service, university affiliated programs, and other appropriate accredited

and accessible entities to enhance the education of Indian students;

''(6) to the maximum extent feasible, uses existing university tutoring, counseling, and student support services; and

''(7) to the maximum extent feasible, employs qualified Indians in the program.

''(e) ACTIVE DUTY SERVICE REQUIREMENT.—The active duty service obligation prescribed under section 338C of the Public Health Service Act (42 U.S.C. 254m) shall be met by each graduate who receives a stipend described in subsection (d)(4) that is funded under this section. Such obligation shall be met by service—

''(1) in an Indian Health Program;

''(2) in a program assisted under title V of this Act; or

''(3) in the private practice of psychology if, as determined by the Secretary, in accordance with guidelines promulgated by the Secretary, such practice is situated in a physician or other health professional shortage area and addresses the health care needs of a substantial number of Indians.

''(f) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated such sums as may be necessary to carry out this section.

"SEC. 106. SCHOLARSHIP PROGRAMS FOR INDIAN TRIBES.

''(a) IN GENERAL.—

''(1) GRANTS AUTHORIZED.—The Secretary, acting through the Service, shall make grants to Tribal Health Programs for the purpose of providing scholarships for Indians to serve as health professionals in Indian communities.

''(2) AMOUNT.—Amounts available under paragraph (1) for any fiscal year shall not exceed 5 percent of the amounts available for each fiscal year for Indian Health Scholarships under section 104.

''(3) APPLICATION.—An application for a grant under paragraph (1) shall be in such form and contain such agreements, assurances, and information as consistent with this section.

''(b) REQUIREMENTS.—

''(1) IN GENERAL.—A Tribal Health Program receiving a grant under subsection (a) shall provide scholarships to Indians in accordance with the requirements of this section.

''(2) COSTS.—With respect to costs of providing any scholarship pursuant to subsection (a)—

''(A) 80 percent of the costs of the scholarship shall be paid from the funds made available pursuant to subsection (a)(1) provided to the Tribal Health Program; and

''(B) 20 percent of such costs may be paid from any other source of funds.

''(c) COURSE OF STUDY.—A Tribal Health Program shall provide scholarships under this section only to Indians enrolled or accepted for enrollment in a course of study (approved by the Secretary) in 1 of the health professions contemplated by this Act.

''(d) CONTRACT.—

''(1) IN GENERAL.—In providing scholarships under subsection (b), the Secretary and the Tribal Health Program shall enter into a written contract with each recipient of such scholarship.

''(2) REQUIREMENTS.—Such contract shall—

''(A) obligate such recipient to provide service in an Indian Health Program or urban Indian organization, in the same Service Area where the Tribal Health Program providing the scholarship is located, for—

''(i) a number of years for which the scholarship is provided (or the part-time equivalent thereof, as determined by the Secretary), or for a period of 2 years, whichever period is greater; or

''(ii) such greater period of time as the recipient and the Tribal Health Program may agree;

''(B) provide that the amount of the scholarship—

''(i) may only be expended for—

''(I) tuition expenses, other reasonable educational expenses, and reasonable living expenses incurred in attendance at the educational institution; and

''(II) payment to the recipient of a monthly stipend of not more than the amount authorized by section 338(g)(1)(B) of the Public Health Service Act (42 U.S.C. 254m(g)(1)(B)), with such amount to be reduced pro rata (as determined by the Secretary) based on the number of hours such student is enrolled, and not to exceed, for any year of attendance for which the scholarship is provided, the total amount required for the year for the purposes authorized in this clause; and

''(ii) may not exceed, for any year of attendance for which the scholarship is provided, the total amount required for the year for the purposes authorized in clause (i);

''(C) require the recipient of such scholarship to maintain an acceptable level of academic standing as determined by the educational institution in accordance with regulations issued pursuant to this Act; and

''(D) require the recipient of such scholarship to meet the educational and licensure requirements appropriate to each health profession.

''(3) SERVICE IN OTHER SERVICE AREAS.—The contract may allow the recipient to serve in another Service Area, provided the Tribal Health Program and Secretary approve and services are not diminished to Indians in the Service Area where the Tribal Health Program providing the scholarship is located.

''(e) BREACH OF CONTRACT.—

''(1) SPECIFIC BREACHES.—An individual who has entered into a written contract with the Secretary and a Tribal Health Program under sub-

section (d) shall be liable to the United States for the Federal share of the amount which has been paid to him or her, or on his or her behalf, under the contract if that individual—

''(A) fails to maintain an acceptable level of academic standing in the educational institution in which he or she is enrolled (such level as determined by the educational institution under regulations of the Secretary);

''(B) is dismissed from such educational institution for disciplinary reasons;

''(C) voluntarily terminates the training in such an educational institution for which he or she is provided a scholarship under such contract before the completion of such training; or

''(D) fails to accept payment, or instructs the educational institution in which he or she is enrolled not to accept payment, in whole or in part, of a scholarship under such contract, in lieu of any service obligation arising under such contract.

''(2) OTHER BREACHES.—If for any reason not specified in paragraph (1), an individual breaches a written contract by failing to either begin such individual's service obligation required under such con-

tract or to complete such service obligation, the United States shall be entitled to recover from the individual an amount determined in accordance with the formula specified in subsection (l) of section 110 in the manner provided for in such subsection.

''(3) CANCELLATION UPON DEATH OF RECIPIENT.—Upon the death of an individual who receives an Indian Health Scholarship, any outstanding obligation of that individual for service or payment that relates to that scholarship shall be canceled.

''(4) INFORMATION.—The Secretary may carry out this subsection on the basis of information received from Tribal Health Programs involved or on the basis of information collected through such other means as the Secretary deems appropriate.

''(f) RELATION TO SOCIAL SECURITY ACT.—The recipient of a scholarship under this section shall agree, in providing health care pursuant to the requirements herein—

''(1) not to discriminate against an individual seeking care on the basis of the ability of the individual to pay for such care or on the basis that payment for such care will be made pursuant to a program established in title XVIII of the Social Secu-

rity Act or pursuant to the programs established in title XIX or title XXI of such Act; and

''(2) to accept assignment under section 1842(b)(3)(B)(ii) of the Social Security Act for all services for which payment may be made under part B of title XVIII of such Act, and to enter into an appropriate agreement with the State agency that administers the State plan for medical assistance under title XIX, or the State child health plan under title XXI, of such Act to provide service to individuals entitled to medical assistance or child health assistance, respectively, under the plan.

''(g) CONTINUANCE OF FUNDING.—The Secretary shall make payments under this section to a Tribal Health Program for any fiscal year subsequent to the first fiscal year of such payments unless the Secretary determines that, for the immediately preceding fiscal year, the Tribal Health Program has not complied with the requirements of this section.

''SEC. 107. INDIAN HEALTH SERVICE EXTERN PROGRAMS.

''(a) EMPLOYMENT PREFERENCE.—Any individual who receives a scholarship pursuant to section 104 or 106 shall be given preference for employment in the Service, or may be employed by a Tribal Health Program or an urban Indian organization, or other agencies of the De-

partment as available, during any nonacademic period of the year.

''(b) NOT COUNTED TOWARD ACTIVE DUTY SERVICE OBLIGATION.—Periods of employment pursuant to this subsection shall not be counted in determining fulfillment of the service obligation incurred as a condition of the scholarship.

''(c) TIMING; LENGTH OF EMPLOYMENT.—Any individual enrolled in a program, including a high school program, authorized under section 102(a) may be employed by the Service or by a Tribal Health Program or an urban Indian organization during any nonacademic period of the year. Any such employment shall not exceed 120 days during any calendar year.

''(d) NONAPPLICABILITY OF COMPETITIVE PERSONNEL SYSTEM.—Any employment pursuant to this section shall be made without regard to any competitive personnel system or agency personnel limitation and to a position which will enable the individual so employed to receive practical experience in the health profession in which he or she is engaged in study. Any individual so employed shall receive payment for his or her services comparable to the salary he or she would receive if he or she were employed in the competitive system. Any individual so em-

ployed shall not be counted against any employment ceiling affecting the Service or the Department.

"SEC. 108. CONTINUING EDUCATION ALLOWANCES.

"In order to encourage scholarship and stipend recipients under sections 104, 105, 106, and 115 and health professionals, including community health representatives and emergency medical technicians, to join or continue in an Indian Health Program and to provide their services in the rural and remote areas where a significant portion of Indians reside, the Secretary, acting through the Service, may—

"(1) provide programs or allowances to transition into an Indian Health Program, including licensing, board or certification examination assistance, and technical assistance in fulfilling service obligations under sections 104, 105, 106, and 115; and

"(2) provide programs or allowances to health professionals employed in an Indian Health Program to enable them for a period of time each year prescribed by regulation of the Secretary to take leave of their duty stations for professional consultation, management, leadership, and refresher training courses.

"SEC. 109. COMMUNITY HEALTH REPRESENTATIVE PROGRAM.

''(a) IN GENERAL.—Under the authority of the Act of November 2, 1921 (25 U.S.C. 13) (commonly known as the 'Snyder Act'), the Secretary, acting through the Service, shall maintain a Community Health Representative Program under which Indian Health Programs—

''(1) provide for the training of Indians as community health representatives; and

''(2) use such community health representatives in the provision of health care, health promotion, and disease prevention services to Indian communities.

''(b) DUTIES.—The Community Health Representative Program of the Service, shall—

''(1) provide a high standard of training for community health representatives to ensure that the community health representatives provide quality health care, health promotion, and disease prevention services to the Indian communities served by the Program;

''(2) in order to provide such training, develop and maintain a curriculum that—

''(A) combines education in the theory of health care with supervised practical experience in the provision of health care; and

''(B) provides instruction and practical experience in health promotion and disease prevention activities, with appropriate consideration given to lifestyle factors that have an impact on Indian health status, such as alcoholism, family dysfunction, and poverty;

''(3) maintain a system which identifies the needs of community health representatives for continuing education in health care, health promotion, and disease prevention and develop programs that meet the needs for continuing education;

''(4) maintain a system that provides close supervision of Community Health Representatives;

''(5) maintain a system under which the work of Community Health Representatives is reviewed and evaluated; and

''(6) promote traditional health care practices of the Indian Tribes served consistent with the Service standards for the provision of health care, health promotion, and disease prevention.

''SEC. 110. INDIAN HEALTH SERVICE LOAN REPAYMENT PROGRAM.

''(a) ESTABLISHMENT.—The Secretary, acting through the Service, shall establish and administer a program to be known as the Service Loan Repayment Pro-

gram (hereinafter referred to as the 'Loan Repayment Program') in order to ensure an adequate supply of trained health professionals necessary to maintain accreditation of, and provide health care services to Indians through, Indian Health Programs and urban Indian organizations.

''(b) ELIGIBLE INDIVIDUALS.—To be eligible to participate in the Loan Repayment Program, an individual must—

''(1)(A) be enrolled—

''(i) in a course of study or program in an accredited educational institution (as determined by the Secretary under section 338B(b)(1)(c)(i) of the Public Health Service Act (42 U.S.C. 254*l*–1(b)(1)(c)(i))) and be scheduled to complete such course of study in the same year such individual applies to participate in such program; or

''(ii) in an approved graduate training program in a health profession; or

''(B) have—

''(i) a degree in a health profession; and

''(ii) a license to practice a health profession;

''(2)(A) be eligible for, or hold, an appointment as a commissioned officer in the Regular or Reserve Corps of the Public Health Service;

''(B) meet the professional standards for civil service employment in the Service; or

''(C) be employed in an Indian Health Program or urban Indian organization without a service obligation; and

''(3) submit to the Secretary an application for a contract described in subsection (e).

''(c) APPLICATION.—

''(1) INFORMATION TO BE INCLUDED WITH FORMS.—In disseminating application forms and contract forms to individuals desiring to participate in the Loan Repayment Program, the Secretary shall include with such forms a fair summary of the rights and liabilities of an individual whose application is approved (and whose contract is accepted) by the Secretary, including in the summary a clear explanation of the damages to which the United States is entitled under subsection (l) in the case of the individual's breach of contract. The Secretary shall provide such individuals with sufficient information regarding the advantages and disadvantages of service as a commissioned officer in the Regular or Re-

serve Corps of the Public Health Service or a civilian employee of the Service to enable the individual to make a decision on an informed basis.

''(2) CLEAR LANGUAGE.—The application form, contract form, and all other information furnished by the Secretary under this section shall be written in a manner calculated to be understood by the average individual applying to participate in the Loan Repayment Program.

''(3) TIMELY AVAILABILITY OF FORMS.—The Secretary shall make such application forms, contract forms, and other information available to individuals desiring to participate in the Loan Repayment Program on a date sufficiently early to ensure that such individuals have adequate time to carefully review and evaluate such forms and information.

''(d) PRIORITIES.—

''(1) LIST.—Consistent with subsection (j), the Secretary shall annually—

''(A) identify the positions in each Indian Health Program or urban Indian organization for which there is a need or a vacancy; and

''(B) rank those positions in order of priority.

''(2) APPROVALS.—Consistent with the priority determined under paragraph (1), the Secretary, in determining which applications under the Loan Repayment Program to approve (and which contracts to accept), shall—

''(A) give first priority to applications made by individual Indians; and

''(B) after making determinations on all applications submitted by individual Indians as required under subparagraph (A), give priority to—

''(i) individuals recruited through the efforts of an Indian Health Program or urban Indian organization; and

''(ii) other individuals based on the priority rankings under paragraph (1).

''(e) RECIPIENT CONTRACTS.—

''(1) CONTRACT REQUIRED.—An individual becomes a participant in the Loan Repayment Program only upon the Secretary and the individual entering into a written contract described in paragraph (2).

''(2) CONTENTS OF CONTRACT.—The written contract referred to in this section between the Secretary and an individual shall contain—

''(A) an agreement under which—

''(i) subject to subparagraph (C), the Secretary agrees—

''(I) to pay loans on behalf of the individual in accordance with the provisions of this section; and

''(II) to accept (subject to the availability of appropriated funds for carrying out this section) the individual into the Service or place the individual with a Tribal Health Program or urban Indian organization as provided in clause (ii)(III); and

''(ii) subject to subparagraph (C), the individual agrees—

''(I) to accept loan payments on behalf of the individual;

''(II) in the case of an individual described in subsection (b)(1)—

''(aa) to maintain enrollment in a course of study or training described in subsection (b)(1)(A) until the individual completes the course of study or training; and

''(bb) while enrolled in such course of study or training, to maintain an acceptable level of academic standing (as determined under regulations of the Secretary by the educational institution offering such course of study or training); and

''(III) to serve for a time period (in this section referred to as the 'period of obligated service') equal to 2 years or such longer period as the individual may agree to serve in the full-time clinical practice of such individual's profession in an Indian Health Program or urban Indian organization to which the individual may be assigned by the Secretary;

''(B) a provision permitting the Secretary to extend for such longer additional periods, as the individual may agree to, the period of obligated service agreed to by the individual under subparagraph (A)(ii)(III);

''(C) a provision that any financial obligation of the United States arising out of a con-

tract entered into under this section and any obligation of the individual which is conditioned thereon is contingent upon funds being appropriated for loan repayments under this section;

''(D) a statement of the damages to which the United States is entitled under subsection (k) for the individual's breach of the contract; and

''(E) such other statements of the rights and liabilities of the Secretary and of the individual, not inconsistent with this section.

''(f) DEADLINE FOR DECISION ON APPLICATION.—The Secretary shall provide written notice to an individual within 21 days on—

''(1) the Secretary's approving, under subsection (e)(1), of the individual's participation in the Loan Repayment Program, including extensions resulting in an aggregate period of obligated service in excess of 4 years; or

''(2) the Secretary's disapproving an individual's participation in such Program.

''(g) PAYMENTS.—

''(1) IN GENERAL.—A loan repayment provided for an individual under a written contract under the Loan Repayment Program shall consist of payment,

in accordance with paragraph (2), on behalf of the individual of the principal, interest, and related expenses on government and commercial loans received by the individual regarding the undergraduate or graduate education of the individual (or both), which loans were made for—

''(A) tuition expenses;

''(B) all other reasonable educational expenses, including fees, books, and laboratory expenses, incurred by the individual; and

''(C) reasonable living expenses as determined by the Secretary.

''(2) AMOUNT.—For each year of obligated service that an individual contracts to serve under subsection (e), the Secretary may pay up to $35,000 or an amount equal to the amount specified in section 338B(g)(2)(A) of the Public Health Service Act, whichever is more, on behalf of the individual for loans described in paragraph (1). In making a determination of the amount to pay for a year of such service by an individual, the Secretary shall consider the extent to which each such determination—

''(A) affects the ability of the Secretary to maximize the number of contracts that can be

provided under the Loan Repayment Program from the amounts appropriated for such contracts;

''(B) provides an incentive to serve in Indian Health Programs and urban Indian organizations with the greatest shortages of health professionals; and

''(C) provides an incentive with respect to the health professional involved remaining in an Indian Health Program or urban Indian organization with such a health professional shortage, and continuing to provide primary health services, after the completion of the period of obligated service under the Loan Repayment Program.

''(3) TIMING.—Any arrangement made by the Secretary for the making of loan repayments in accordance with this subsection shall provide that any repayments for a year of obligated service shall be made no later than the end of the fiscal year in which the individual completes such year of service.

''(4) REIMBURSEMENTS FOR TAX LIABILITY.—For the purpose of providing reimbursements for tax liability resulting from a payment under paragraph (2) on behalf of an individual, the Secretary—

''(A) in addition to such payments, may make payments to the individual in an amount equal to not less than 20 percent and not more than 39 percent of the total amount of loan repayments made for the taxable year involved; and

''(B) may make such additional payments as the Secretary determines to be appropriate with respect to such purpose.

''(5) PAYMENT SCHEDULE.—The Secretary may enter into an agreement with the holder of any loan for which payments are made under the Loan Repayment Program to establish a schedule for the making of such payments.

''(h) EMPLOYMENT CEILING.—Notwithstanding any other provision of law, individuals who have entered into written contracts with the Secretary under this section shall not be counted against any employment ceiling affecting the Department while those individuals are undergoing academic training.

''(i) RECRUITMENT.—The Secretary shall conduct recruiting programs for the Loan Repayment Program and other manpower programs of the Service at educational institutions training health professionals or specialists identified in subsection (a).

''(j) APPLICABILITY OF LAW.—Section 214 of the Public Health Service Act (42 U.S.C. 215) shall not apply to individuals during their period of obligated service under the Loan Repayment Program.

''(k) ASSIGNMENT OF INDIVIDUALS.—The Secretary, in assigning individuals to serve in Indian Health Programs or urban Indian organizations pursuant to contracts entered into under this section, shall—

''(1) ensure that the staffing needs of Tribal Health Programs and urban Indian organizations receive consideration on an equal basis with programs that are administered directly by the Service; and

''(2) give priority to assigning individuals to Indian Health Programs and urban Indian organizations that have a need for health professionals to provide health care services as a result of individuals having breached contracts entered into under this section.

''(l) BREACH OF CONTRACT.—

''(1) SPECIFIC BREACHES.—An individual who has entered into a written contract with the Secretary under this section and has not received a waiver under subsection (m) shall be liable, in lieu of any service obligation arising under such contract,

to the United States for the amount which has been paid on such individual's behalf under the contract if that individual—

''(A) is enrolled in the final year of a course of study and—

''(i) fails to maintain an acceptable level of academic standing in the educational institution in which he or she is enrolled (such level determined by the educational institution under regulations of the Secretary);

''(ii) voluntarily terminates such enrollment; or

''(iii) is dismissed from such educational institution before completion of such course of study; or

''(B) is enrolled in a graduate training program and fails to complete such training program.

''(2) OTHER BREACHES; FORMULA FOR AMOUNT OWED.—If, for any reason not specified in paragraph (1), an individual breaches his or her written contract under this section by failing either to begin, or complete, such individual's period of obligated service in accordance with subsection (e)(2),

the United States shall be entitled to recover from such individual an amount to be determined in accordance with the following formula: A=3Z(t−s/t) in which—

''(A) 'A' is the amount the United States is entitled to recover;

''(B) 'Z' is the sum of the amounts paid under this section to, or on behalf of, the individual and the interest on such amounts which would be payable if, at the time the amounts were paid, they were loans bearing interest at the maximum legal prevailing rate, as determined by the Secretary of the Treasury;

''(C) 't' is the total number of months in the individual's period of obligated service; and

''(D) 's' is the number of months of such period served by such individual in accordance with this section.

''(3) TIME PERIOD FOR REPAYMENT.—Any amount of damages which the United States is entitled to recover under this subsection shall be paid to the United States within the 1-year period beginning on the date of the breach or such longer period beginning on such date as shall be specified by the Secretary.

''(4) DEDUCTIONS IN MEDICARE PAYMENTS.—Amounts not paid within such period shall be subject to collection through deductions in Medicare payments pursuant to section 1892 of the Social Security Act.

''(5) RECOVERY OF DELINQUENCY.—

''(A) IN GENERAL.—If damages described in paragraph (4) are delinquent for 3 months, the Secretary shall, for the purpose of recovering such damages—

''(i) use collection agencies contracted with by the Administrator of General Services; or

''(ii) enter into contracts for the recovery of such damages with collection agencies selected by the Secretary.

''(B) REPORT.—Each contract for recovering damages pursuant to this subsection shall provide that the contractor will, not less than once each 6 months, submit to the Secretary a status report on the success of the contractor in collecting such damages. Section 3718 of title 31, United States Code, shall apply to any such contract to the extent not inconsistent with this subsection.

''(m) WAIVER OR SUSPENSION OF OBLIGATION.—

''(1) IN GENERAL.—The Secretary shall by regulation provide for the partial or total waiver or suspension of any obligation of service or payment by an individual under the Loan Repayment Program whenever compliance by the individual is impossible or would involve extreme hardship to the individual and if enforcement of such obligation with respect to any individual would be unconscionable.

''(2) CANCELED UPON DEATH.—Any obligation of an individual under the Loan Repayment Program for service or payment of damages shall be canceled upon the death of the individual.

''(3) HARDSHIP WAIVER.—The Secretary may waive, in whole or in part, the rights of the United States to recover amounts under this section in any case of extreme hardship or other good cause shown, as determined by the Secretary.

''(4) BANKRUPTCY.—Any obligation of an individual under the Loan Repayment Program for payment of damages may be released by a discharge in bankruptcy under title 11 of the United States Code only if such discharge is granted after the expiration of the 5-year period beginning on the first date that payment of such damages is required, and only if

the bankruptcy court finds that nondischarge of the obligation would be unconscionable.

''(n) REPORT.—The Secretary shall submit to the President, for inclusion in the report required to be submitted to Congress under section 801, a report concerning the previous fiscal year which sets forth by Service Area the following:

''(1) A list of the health professional positions maintained by Indian Health Programs and urban Indian organizations for which recruitment or retention is difficult.

''(2) The number of Loan Repayment Program applications filed with respect to each type of health profession.

''(3) The number of contracts described in subsection (e) that are entered into with respect to each health profession.

''(4) The amount of loan payments made under this section, in total and by health profession.

''(5) The number of scholarships that are provided under sections 104 and 106 with respect to each health profession.

''(6) The amount of scholarship grants provided under sections 104 and 106, in total and by health profession.

''(7) The number of providers of health care that will be needed by Indian Health Programs and urban Indian organizations, by location and profession, during the 3 fiscal years beginning after the date the report is filed.

''(8) The measures the Secretary plans to take to fill the health professional positions maintained by Indian Health Programs or urban Indian organizations for which recruitment or retention is difficult.

''SEC. 111. SCHOLARSHIP AND LOAN REPAYMENT RECOVERY FUND.

''(a) ESTABLISHMENT.—There is established in the Treasury of the United States a fund to be known as the Indian Health Scholarship and Loan Repayment Recovery Fund (hereafter in this section referred to as the 'LRRF'). The LRRF shall consist of such amounts as may be collected from individuals under section 104(d), section 106(e), and section 110(l) for breach of contract, such funds as may be appropriated to the LRRF, and interest earned on amounts in the LRRF. All amounts collected, appropriated, or earned relative to the LRRF shall remain available until expended.

''(b) USE OF FUNDS.—

''(1) BY SECRETARY.—Amounts in the LRRF may be expended by the Secretary, acting through the Service, to make payments to an Indian Health Program—

''(A) to which a scholarship recipient under section 104 and 106 or a loan repayment program participant under section 110 has been assigned to meet the obligated service requirements pursuant to such sections; and

''(B) that has a need for a health professional to provide health care services as a result of such recipient or participant having breached the contract entered into under section 104, 106, or 110.

''(2) BY TRIBAL HEALTH PROGRAMS.—A Tribal Health Program receiving payments pursuant to paragraph (1) may expend the payments to provide scholarships or recruit and employ, directly or by contract, health professionals to provide health care services.

''(c) INVESTMENT OF FUNDS.—The Secretary of the Treasury shall invest such amounts of the LRRF as the Secretary of Health and Human Services determines are not required to meet current withdrawals from the LRRF. Such investments may be made only in interest bearing

obligations of the United States. For such purpose, such obligations may be acquired on original issue at the issue price, or by purchase of outstanding obligations at the market price.

''(d) SALE OF OBLIGATIONS.—Any obligation acquired by the LRRF may be sold by the Secretary of the Treasury at the market price.

''SEC. 112. RECRUITMENT ACTIVITIES.

''(a) REIMBURSEMENT FOR TRAVEL.—The Secretary, acting through the Service, may reimburse health professionals seeking positions with Indian Health Programs or urban Indian organizations, including individuals considering entering into a contract under section 110 and their spouses, for actual and reasonable expenses incurred in traveling to and from their places of residence to an area in which they may be assigned for the purpose of evaluating such area with respect to such assignment.

''(b) RECRUITMENT PERSONNEL.—The Secretary, acting through the Service, shall assign 1 individual in each Area Office to be responsible on a full-time basis for recruitment activities.

''SEC. 113. INDIAN RECRUITMENT AND RETENTION PROGRAM.

''(a) IN GENERAL.—The Secretary, acting through the Service, shall fund, on a competitive basis, innovative

demonstration projects for a period not to exceed 3 years to enable Indian Health Programs and urban Indian organizations to recruit, place, and retain health professionals to meet their staffing needs.

''(b) ELIGIBLE ENTITIES; APPLICATION.—Any Indian Health Program or Urban Indian organization may submit an application for funding of a project pursuant to this section.

''SEC. 114. ADVANCED TRAINING AND RESEARCH.

''(a) DEMONSTRATION PROGRAM.—The Secretary, acting through the Service, shall establish a demonstration project to enable health professionals who have worked in an Indian Health Program or urban Indian organization for a substantial period of time to pursue advanced training or research areas of study for which the Secretary determines a need exists.

''(b) SERVICE OBLIGATION.—An individual who participates in a program under subsection (a), where the educational costs are borne by the Service, shall incur an obligation to serve in an Indian Health Program or urban Indian organization for a period of obligated service equal to at least the period of time during which the individual participates in such program. In the event that the individual fails to complete such obligated service, the individual shall be liable to the United States for the period

of service remaining. In such event, with respect to individuals entering the program after the date of enactment of the Indian Health Care Improvement Act Amendments of 2009, the United States shall be entitled to recover from such individual an amount to be determined in accordance with the formula specified in subsection (l) of section 110 in the manner provided for in such subsection.

''(c) EQUAL OPPORTUNITY FOR PARTICIPATION.—Health professionals from Tribal Health Programs and urban Indian organizations shall be given an equal opportunity to participate in the program under subsection (a).

''SEC. 115. QUENTIN N. BURDICK AMERICAN INDIANS INTO NURSING PROGRAM.

''(a) GRANTS AUTHORIZED.—For the purpose of increasing the number of nurses, nurse midwives, and nurse practitioners who deliver health care services to Indians, the Secretary, acting through the Service, shall provide grants to the following:

''(1) Public or private schools of nursing.

''(2) Tribal colleges or universities.

''(3) Nurse midwife programs and advanced practice nurse programs that are provided by any tribal college or university accredited nursing program, or in the absence of such, any other public or private institutions.

''(b) USE OF GRANTS.—Grants provided under subsection (a) may be used for 1 or more of the following:

''(1) To recruit individuals for programs which train individuals to be nurses, nurse midwives, or advanced practice nurses.

''(2) To provide scholarships to Indians enrolled in such programs that may pay the tuition charged for such program and other expenses incurred in connection with such program, including books, fees, room and board, and stipends for living expenses.

''(3) To provide a program that encourages nurses, nurse midwives, and advanced practice nurses to provide, or continue to provide, health care services to Indians.

''(4) To provide a program that increases the skills of, and provides continuing education to, nurses, nurse midwives, and advanced practice nurses.

''(5) To provide any program that is designed to achieve the purpose described in subsection (a).

''(c) APPLICATIONS.—Each application for a grant under subsection (a) shall include such information as the Secretary may require to establish the connection between the program of the applicant and a health care facility that primarily serves Indians.

''(d) PREFERENCES FOR GRANT RECIPIENTS.—In providing grants under subsection (a), the Secretary shall extend a preference to the following:

''(1) Programs that provide a preference to Indians.

''(2) Programs that train nurse midwives or advanced practice nurses.

''(3) Programs that are interdisciplinary.

''(4) Programs that are conducted in cooperation with a program for gifted and talented Indian students.

''(5) Programs conducted by tribal colleges and universities.

''(e) QUENTIN N. BURDICK PROGRAM GRANT.—The Secretary shall provide 1 of the grants authorized under subsection (a) to establish and maintain a program at the University of North Dakota to be known as the 'Quentin N. Burdick American Indians Into Nursing Program'. Such program shall, to the maximum extent feasible, coordinate with the Quentin N. Burdick Indian Health Programs established under section 117(b) and the Quentin N. Burdick American Indians Into Psychology Program established under section 105(b).

''(f) ACTIVE DUTY SERVICE OBLIGATION.—The active duty service obligation prescribed under section 338C

of the Public Health Service Act (42 U.S.C. 254m) shall be met by each individual who receives training or assistance described in paragraph (1) or (2) of subsection (b) that is funded by a grant provided under subsection (a). Such obligation shall be met by service—

''(1) in the Service;

''(2) in a program of an Indian Tribe or Tribal Organization conducted under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.) (including programs under agreements with the Bureau of Indian Affairs);

''(3) in a program assisted under title V of this Act;

''(4) in the private practice of nursing if, as determined by the Secretary, in accordance with guidelines promulgated by the Secretary, such practice is situated in a physician or other health shortage area and addresses the health care needs of a substantial number of Indians; or

''(5) in a teaching capacity in a tribal college or university nursing program (or a related health profession program) if, as determined by the Secretary, health services provided to Indians would not decrease.

"SEC. 116. TRIBAL CULTURAL ORIENTATION.

"(a) CULTURAL EDUCATION OF EMPLOYEES.—The Secretary, acting through the Service, shall require that appropriate employees of the Service who serve Indian Tribes in each Service Area receive educational instruction in the history and culture of such Indian Tribes and their relationship to the Service.

"(b) PROGRAM.—In carrying out subsection (a), the Secretary shall establish a program which shall, to the extent feasible—

"(1) be developed in consultation with the affected Indian Tribes, Tribal Organizations, and urban Indian organizations;

"(2) be carried out through tribal colleges or universities;

"(3) include instruction in American Indian studies; and

"(4) describe the use and place of traditional health care practices of the Indian Tribes in the Service Area.

"SEC. 117. INMED PROGRAM.

"(a) GRANTS AUTHORIZED.—The Secretary, acting through the Service, is authorized to provide grants to colleges and universities for the purpose of maintaining and expanding the Indian health careers recruitment program known as the 'Indians Into Medicine Program' (herein-

after in this section referred to as 'INMED') as a means of encouraging Indians to enter the health professions.

''(b) QUENTIN N. BURDICK GRANT.—The Secretary shall provide 1 of the grants authorized under subsection (a) to maintain the INMED program at the University of North Dakota, to be known as the 'Quentin N. Burdick Indian Health Programs', unless the Secretary makes a determination, based upon program reviews, that the program is not meeting the purposes of this section. Such program shall, to the maximum extent feasible, coordinate with the Quentin N. Burdick American Indians Into Psychology Program established under section 105(b) and the Quentin N. Burdick American Indians Into Nursing Program established under section 115.

''(c) REGULATIONS.—The Secretary, pursuant to this Act, shall develop regulations to govern grants pursuant to this section.

''(d) REQUIREMENTS.—Applicants for grants provided under this section shall agree to provide a program which—

''(1) provides outreach and recruitment for health professions to Indian communities including elementary and secondary schools and community colleges located on reservations which will be served by the program;

''(2) incorporates a program advisory board comprised of representatives from the Indian Tribes and Indian communities which will be served by the program;

''(3) provides summer preparatory programs for Indian students who need enrichment in the subjects of math and science in order to pursue training in the health professions;

''(4) provides tutoring, counseling, and support to students who are enrolled in a health career program of study at the respective college or university; and

''(5) to the maximum extent feasible, employs qualified Indians in the program.

''SEC. 118. HEALTH TRAINING PROGRAMS OF COMMUNITY COLLEGES.

''(a) GRANTS TO ESTABLISH PROGRAMS.—

''(1) IN GENERAL.—The Secretary, acting through the Service, shall award grants to accredited and accessible community colleges for the purpose of assisting such community colleges in the establishment of programs which provide education in a health profession leading to a degree or diploma in a health profession for individuals who desire to

practice such profession on or near a reservation or in an Indian Health Program.

''(2) AMOUNT OF GRANTS.—The amount of any grant awarded to a community college under paragraph (1) for the first year in which such a grant is provided to the community college shall not exceed $250,000.

''(b) GRANTS FOR MAINTENANCE AND RECRUITING.—

''(1) IN GENERAL.—The Secretary, acting through the Service, shall award grants to accredited and accessible community colleges that have established a program described in subsection (a)(1) for the purpose of maintaining the program and recruiting students for the program.

''(2) REQUIREMENTS.—Grants may only be made under this section to a community college which—

''(A) is accredited;

''(B) has a relationship with a hospital facility, Service facility, or hospital that could provide training of nurses or health professionals;

''(C) has entered into an agreement with an accredited college or university medical school, the terms of which—

''(i) provide a program that enhances the transition and recruitment of students into advanced baccalaureate or graduate programs that train health professionals; and

''(ii) stipulate certifications necessary to approve internship and field placement opportunities at Indian Health Programs;

''(D) has a qualified staff which has the appropriate certifications;

''(E) is capable of obtaining State or regional accreditation of the program described in subsection (a)(1); and

''(F) agrees to provide for Indian preference for applicants for programs under this section.

''(c) TECHNICAL ASSISTANCE.—The Secretary shall encourage community colleges described in subsection (b)(2) to establish and maintain programs described in subsection (a)(1) by—

''(1) entering into agreements with such colleges for the provision of qualified personnel of the

Service to teach courses of study in such programs; and

''(2) providing technical assistance and support to such colleges.

''(d) ADVANCED TRAINING.—

''(1) REQUIRED.—Any program receiving assistance under this section that is conducted with respect to a health profession shall also offer courses of study which provide advanced training for any health professional who—

''(A) has already received a degree or diploma in such health profession; and

''(B) provides clinical services on or near a reservation or for an Indian Health Program.

''(2) MAY BE OFFERED AT ALTERNATE SITE.—Such courses of study may be offered in conjunction with the college or university with which the community college has entered into the agreement required under subsection (b)(2)(C).

''(e) PRIORITY.—Where the requirements of subsection (b) are met, grant award priority shall be provided to tribal colleges and universities in Service Areas where they exist.

"SEC. 119. RETENTION BONUS.

"(a) BONUS AUTHORIZED.—The Secretary may pay a retention bonus to any health professional employed by, or assigned to, and serving in, an Indian Health Program or urban Indian organization either as a civilian employee or as a commissioned officer in the Regular or Reserve Corps of the Public Health Service who—

"(1) is assigned to, and serving in, a position for which recruitment or retention of personnel is difficult;

"(2) the Secretary determines is needed by Indian Health Programs and urban Indian organizations;

"(3) has—

"(A) completed 2 years of employment with an Indian Health Program or urban Indian organization; or

"(B) completed any service obligations incurred as a requirement of—

"(i) any Federal scholarship program; or

"(ii) any Federal education loan repayment program; and

"(4) enters into an agreement with an Indian Health Program or urban Indian organization for

continued employment for a period of not less than 1 year.

''(b) RATES.—The Secretary may establish rates for the retention bonus which shall provide for a higher annual rate for multiyear agreements than for single year agreements referred to in subsection (a)(4), but in no event shall the annual rate be more than $25,000 per annum.

''(c) DEFAULT OF RETENTION AGREEMENT.—Any health professional failing to complete the agreed upon term of service, except where such failure is through no fault of the individual, shall be obligated to refund to the Government the full amount of the retention bonus for the period covered by the agreement, plus interest as determined by the Secretary in accordance with section 110(l)(2)(B).

''(d) OTHER RETENTION BONUS.—The Secretary may pay a retention bonus to any health professional employed by a Tribal Health Program if such health professional is serving in a position which the Secretary determines is—

''(1) a position for which recruitment or retention is difficult; and

''(2) necessary for providing health care services to Indians.

"SEC. 120. NURSING RESIDENCY PROGRAM.

''(a) ESTABLISHMENT OF PROGRAM.—The Secretary, acting through the Service, shall establish a program to enable Indians who are licensed practical nurses, licensed vocational nurses, and registered nurses who are working in an Indian Health Program or urban Indian organization, and have done so for a period of not less than 1 year, to pursue advanced training. Such program shall include a combination of education and work study in an Indian Health Program or urban Indian organization leading to an associate or bachelor's degree (in the case of a licensed practical nurse or licensed vocational nurse), a bachelor's degree (in the case of a registered nurse), or advanced degrees or certifications in nursing and public health.

''(b) SERVICE OBLIGATION.—An individual who participates in a program under subsection (a), where the educational costs are paid by the Service, shall incur an obligation to serve in an Indian Health Program or urban Indian organization for a period of obligated service equal to 1 year for every year that nonprofessional employee (licensed practical nurses, licensed vocational nurses, nursing assistants, and various health care technicians), or 2 years for every year that professional nurse (associate degree and bachelor-prepared registered nurses), participates in such program. In the event that the individual

fails to complete such obligated service, the United States shall be entitled to recover from such individual an amount determined in accordance with the formula specified subsection (d)(1) of Section 104 for individuals failing to graduate from their degree program and subsection (l) of Section 110 for individuals failing to start or complete the obligated service.

"SEC. 121. COMMUNITY HEALTH AIDE PROGRAM.

''(a) GENERAL PURPOSES OF PROGRAM.—Under the authority of the Act of November 2, 1921 (25 U.S.C. 13) (commonly known as the 'Snyder Act'), the Secretary, acting through the Service, shall develop and operate a Community Health Aide Program in Alaska under which the Service—

''(1) provides for the training of Alaska Natives as health aides or community health practitioners;

''(2) uses such aides or practitioners in the provision of health care, health promotion, and disease prevention services to Alaska Natives living in villages in rural Alaska; and

''(3) provides for the establishment of teleconferencing capacity in health clinics located in or near such villages for use by community health aides or community health practitioners.

''(b) SPECIFIC PROGRAM REQUIREMENTS.—The Secretary, acting through the Community Health Aide Program of the Service, shall—

''(1) using trainers accredited by the Program, provide a high standard of training to community health aides and community health practitioners to ensure that such aides and practitioners provide quality health care, health promotion, and disease prevention services to the villages served by the Program;

''(2) in order to provide such training, develop a curriculum that—

''(A) combines education in the theory of health care with supervised practical experience in the provision of health care;

''(B) provides instruction and practical experience in the provision of acute care, emergency care, health promotion, disease prevention, and the efficient and effective management of clinic pharmacies, supplies, equipment, and facilities; and

''(C) promotes the achievement of the health status objectives specified in section 3(2);

''(3) establish and maintain a Community Health Aide Certification Board to certify as community health aides or community health practitioners individuals who have successfully completed the training described in paragraph (1) or can demonstrate equivalent experience;

''(4) develop and maintain a system which identifies the needs of community health aides and community health practitioners for continuing education in the provision of health care, including the areas described in paragraph (2)(B), and develop programs that meet the needs for such continuing education;

''(5) develop and maintain a system that provides close supervision of community health aides and community health practitioners;

''(6) develop a system under which the work of community health aides and community health practitioners is reviewed and evaluated to assure the provision of quality health care, health promotion, and disease prevention services; and

''(7) ensure that pulpal therapy (not including pulpotomies on deciduous teeth) or extraction of adult teeth can be performed by a dental health aide therapist only after consultation with a licensed den-

tist who determines that the procedure is a medical emergency that cannot be resolved with palliative treatment, and further that dental health aide therapists are strictly prohibited from performing all other oral or jaw surgeries, provided that uncomplicated extractions shall not be considered oral surgery under this section.

''(c) PROGRAM REVIEW.—

''(1) NEUTRAL PANEL.—

''(A) ESTABLISHMENT.—The Secretary, acting through the Service, shall establish a neutral panel to carry out the study under paragraph (2).

''(B) MEMBERSHIP.—Members of the neutral panel shall be appointed by the Secretary from among clinicians, economists, community practitioners, oral epidemiologists, and Alaska Natives.

''(2) STUDY.—

''(A) IN GENERAL.—The neutral panel established under paragraph (1) shall conduct a study of the dental health aide therapist services provided by the Community Health Aide Program under this section to ensure that the

quality of care provided through those services is adequate and appropriate.

''(B) PARAMETERS OF STUDY.—The Secretary, in consultation with interested parties, including professional dental organizations, shall develop the parameters of the study.

''(C) INCLUSIONS.—The study shall include a determination by the neutral panel with respect to—

''(i) the ability of the dental health aide therapist services under this section to address the dental care needs of Alaska Natives;

''(ii) the quality of care provided through those services, including any training, improvement, or additional oversight required to improve the quality of care; and

''(iii) whether safer and less costly alternatives to the dental health aide therapist services exist.

''(D) CONSULTATION.—In carrying out the study under this paragraph, the neutral panel shall consult with Alaska Tribal Organizations

with respect to the adequacy and accuracy of the study.

''(3) REPORT.—The neutral panel shall submit to the Secretary, the Committee on Indian Affairs of the Senate, and the Committee on Natural Resources of the House of Representatives a report describing the results of the study under paragraph (2), including a description of—

''(A) any determination of the neutral panel under paragraph (2)(C); and

''(B) any comments received from an Alaska Tribal Organization under paragraph (2)(D).

''(d) NATIONALIZATION OF PROGRAM.—

''(1) IN GENERAL.—Except as provided in paragraph (2), the Secretary, acting through the Service, may establish a national Community Health Aide Program in accordance with the program under this section, as the Secretary determines to be appropriate.

''(2) EXCEPTION.—The national Community Health Aide Program under paragraph (1) shall not include dental health aide therapist services.

''(3) REQUIREMENT.—In establishing a national program under paragraph (1), the Secretary

shall not reduce the amount of funds provided for the Community Health Aide Program described in subsections (a) and (b).

"SEC. 122. TRIBAL HEALTH PROGRAM ADMINISTRATION.

''The Secretary shall, by contract or otherwise, provide training for individuals in the administration and planning of Tribal Health Programs, with priority to Indians.

"SEC. 123. HEALTH PROFESSIONAL CHRONIC SHORTAGE DEMONSTRATION PROGRAMS.

''(a) DEMONSTRATION PROGRAMS AUTHORIZED.—The Secretary, acting through the Service, may fund demonstration programs for Tribal Health Programs to address the chronic shortages of health professionals.

''(b) PURPOSES OF PROGRAMS.—The purposes of demonstration programs funded under subsection (a) shall be—

''(1) to provide direct clinical and practical experience at a Service Unit to health profession students and residents from medical schools;

''(2) to improve the quality of health care for Indians by assuring access to qualified health care professionals; and

''(3) to provide academic and scholarly opportunities for health professionals serving Indians by

identifying all academic and scholarly resources of the region.

''(c) ADVISORY BOARD.—The demonstration programs established pursuant to subsection (a) shall incorporate a program advisory board composed of representatives from the Indian Tribes and Indian communities in the area which will be served by the program.

"SEC. 124. NATIONAL HEALTH SERVICE CORPS.

''(a) NO REDUCTION IN SERVICES.—The Secretary shall not—

''(1) remove a member of the National Health Service Corps from an Indian Health Program or urban Indian organization; or

''(2) withdraw funding used to support such member, unless the Secretary, acting through the Service, has ensured that the Indians receiving services from such member will experience no reduction in services.

''(b) TREATMENT OF INDIAN HEALTH PROGRAMS.—At the request of an Indian Health Program, the services of a member of the National Health Service Corps assigned to an Indian Health Program may be limited to the persons who are eligible for services from such Program.

"SEC. 125. SUBSTANCE ABUSE COUNSELOR EDUCATIONAL CURRICULA DEMONSTRATION PROGRAMS.

''(a) CONTRACTS AND GRANTS.—The Secretary, acting through the Service, may enter into contracts with, or make grants to, accredited tribal colleges and universities and eligible accredited and accessible community colleges to establish demonstration programs to develop educational curricula for substance abuse counseling.

''(b) USE OF FUNDS.—Funds provided under this section shall be used only for developing and providing educational curriculum for substance abuse counseling (including paying salaries for instructors). Such curricula may be provided through satellite campus programs.

''(c) TIME PERIOD OF ASSISTANCE; RENEWAL.—A contract entered into or a grant provided under this section shall be for a period of 3 years. Such contract or grant may be renewed for an additional 2-year period upon the approval of the Secretary.

''(d) CRITERIA FOR REVIEW AND APPROVAL OF APPLICATIONS.—Not later than 180 days after the date of enactment of the Indian Health Care Improvement Act Amendments of 2009, the Secretary, after consultation with Indian Tribes and administrators of tribal colleges and universities and eligible accredited and accessible community colleges, shall develop and issue criteria for the review and approval of applications for funding (including

applications for renewals of funding) under this section. Such criteria shall ensure that demonstration programs established under this section promote the development of the capacity of such entities to educate substance abuse counselors.

''(e) ASSISTANCE.—The Secretary shall provide such technical and other assistance as may be necessary to enable grant recipients to comply with the provisions of this section.

''(f) REPORT.—Each fiscal year, the Secretary shall submit to the President, for inclusion in the report which is required to be submitted under section 801 for that fiscal year, a report on the findings and conclusions derived from the demonstration programs conducted under this section during that fiscal year.

''(g) DEFINITION.—For the purposes of this section, the term 'educational curriculum' means 1 or more of the following:

''(1) Classroom education.

''(2) Clinical work experience.

''(3) Continuing education workshops.

''SEC. 126. BEHAVIORAL HEALTH TRAINING AND COMMUNITY EDUCATION PROGRAMS.

''(a) STUDY; LIST.—The Secretary, acting through the Service, and the Secretary of the Interior, in consulta-

tion with Indian Tribes and Tribal Organizations, shall conduct a study and compile a list of the types of staff positions specified in subsection (b) whose qualifications include, or should include, training in the identification, prevention, education, referral, or treatment of mental illness, or dysfunctional and self-destructive behavior.

''(b) POSITIONS.—The positions referred to in subsection (a) are—

''(1) staff positions within the Bureau of Indian Affairs, including existing positions, in the fields of—

''(A) elementary and secondary education;

''(B) social services and family and child welfare;

''(C) law enforcement and judicial services; and

''(D) alcohol and substance abuse;

''(2) staff positions within the Service; and

''(3) staff positions similar to those identified in paragraphs (1) and (2) established and maintained by Indian Tribes, Tribal Organizations (without regard to the funding source), and urban Indian organizations.

''(c) TRAINING CRITERIA.—

''(1) IN GENERAL.—The appropriate Secretary shall provide training criteria appropriate to each type of position identified in subsection (b)(1) and (b)(2) and ensure that appropriate training has been, or shall be provided to any individual in any such position. With respect to any such individual in a position identified pursuant to subsection (b)(3), the respective Secretaries shall provide appropriate training to, or provide funds to, an Indian Tribe, Tribal Organization, or urban Indian organization for training of appropriate individuals. In the case of positions funded under a contract or compact under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.), the appropriate Secretary shall ensure that such training costs are included in the contract or compact, as the Secretary determines necessary.

''(2) POSITION SPECIFIC TRAINING CRITERIA.—Position specific training criteria shall be culturally relevant to Indians and Indian Tribes and shall ensure that appropriate information regarding traditional health care practices is provided.

''(d) COMMUNITY EDUCATION ON MENTAL ILLNESS.—The Service shall develop and implement, on request of an Indian Tribe, Tribal Organization, or urban

Indian organization, or assist the Indian Tribe, Tribal Organization, or urban Indian organization to develop and implement, a program of community education on mental illness. In carrying out this subsection, the Service shall, upon request of an Indian Tribe, Tribal Organization, or urban Indian organization, provide technical assistance to the Indian Tribe, Tribal Organization, or urban Indian organization to obtain and develop community educational materials on the identification, prevention, referral, and treatment of mental illness and dysfunctional and self-destructive behavior.

''(e) PLAN.—Not later than 90 days after the date of enactment of the Indian Health Care Improvement Act Amendments of 2009, the Secretary shall develop a plan under which the Service will increase the health care staff providing behavioral health services by at least 500 positions within 5 years after the date of enactment of this section, with at least 200 of such positions devoted to child, adolescent, and family services. The plan developed under this subsection shall be implemented under the Act of November 2, 1921 (25 U.S.C. 13) (commonly known as the 'Snyder Act').

''SEC. 127. EXEMPTION FROM PAYMENT OF CERTAIN FEES.

''Employees of a Tribal Health Program or an Urban Indian Organization shall be exempt from payment of li-

censing, registration, and other fees imposed by a Federal agency to the same extent that Commissioned Corps Officers or other employees of the Indian Health Service are exempt from such fees.

"SEC. 128. AUTHORIZATION OF APPROPRIATIONS.

''There are authorized to be appropriated such sums as may be necessary to carry out this title.

"TITLE II—HEALTH SERVICES

"SEC. 201. INDIAN HEALTH CARE IMPROVEMENT FUND.

''(a) USE OF FUNDS.—The Secretary, acting through the Service, is authorized to expend funds, directly or under the authority of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.), which are appropriated under the authority of this section, for the purposes of—

''(1) eliminating the deficiencies in health status and health resources of all Indian Tribes;

''(2) eliminating backlogs in the provision of health care services to Indians;

''(3) meeting the health needs of Indians in an efficient and equitable manner, including the use of telehealth and telemedicine when appropriate;

''(4) eliminating inequities in funding for both direct care and contract health service programs; and

''(5) augmenting the ability of the Service to meet the following health service responsibilities with respect to those Indian Tribes with the highest levels of health status deficiencies and resource deficiencies:

''(A) Clinical care, including inpatient care, outpatient care (including audiology, clinical eye, and vision care), primary care, secondary and tertiary care, and long-term care.

''(B) Preventive health, including mammography and other cancer screening in accordance with section 207.

''(C) Dental care.

''(D) Mental health, including community mental health services, inpatient mental health services, dormitory mental health services, therapeutic and residential treatment centers, and training of traditional health care practitioners.

''(E) Emergency medical services.

''(F) Treatment and control of, and rehabilitative care related to, alcoholism and drug abuse (including fetal alcohol syndrome) among Indians.

''(G) Injury prevention programs, including data collection and evaluation, demonstration projects, training, and capacity building.

''(H) Home health care.

''(I) Community health representatives.

''(J) Maintenance and improvement.

''(b) NO OFFSET OR LIMITATION.—Any funds appropriated under the authority of this section shall not be used to offset or limit any other appropriations made to the Service under this Act or the Act of November 2, 1921 (25 U.S.C. 13) (commonly known as the 'Snyder Act'), or any other provision of law.

''(c) ALLOCATION; USE.—

''(1) IN GENERAL.—Funds appropriated under the authority of this section shall be allocated to Service Units, Indian Tribes, or Tribal Organizations. The funds allocated to each Indian Tribe, Tribal Organization, or Service Unit under this paragraph shall be used by the Indian Tribe, Tribal Organization, or Service Unit under this paragraph to improve the health status and reduce the resource deficiency of each Indian Tribe served by such Service Unit, Indian Tribe, or Tribal Organization.

''(2) APPORTIONMENT OF ALLOCATED FUNDS.—The apportionment of funds allocated to a

Service Unit, Indian Tribe, or Tribal Organization under paragraph (1) among the health service responsibilities described in subsection (a)(5) shall be determined by the Service in consultation with, and with the active participation of, the affected Indian Tribes and Tribal Organizations.

''(d) PROVISIONS RELATING TO HEALTH STATUS AND RESOURCE DEFICIENCIES.—For the purposes of this section, the following definitions apply:

''(1) DEFINITION.—The term 'health status and resource deficiency' means the extent to which—

''(A) the health status objectives set forth in section 3(2) are not being achieved; and

''(B) the Indian Tribe or Tribal Organization does not have available to it the health resources it needs, taking into account the actual cost of providing health care services given local geographic, climatic, rural, or other circumstances.

''(2) AVAILABLE RESOURCES.—The health resources available to an Indian Tribe or Tribal Organization include health resources provided by the Service as well as health resources used by the Indian Tribe or Tribal Organization, including services

and financing systems provided by any Federal programs, private insurance, and programs of State or local governments.

''(3) PROCESS FOR REVIEW OF DETERMINATIONS.—The Secretary shall establish procedures which allow any Indian Tribe or Tribal Organization to petition the Secretary for a review of any determination of the extent of the health status and resource deficiency of such Indian Tribe or Tribal Organization.

''(e) ELIGIBILITY FOR FUNDS.—Tribal Health Programs shall be eligible for funds appropriated under the authority of this section on an equal basis with programs that are administered directly by the Service.

''(f) REPORT.—By no later than the date that is 3 years after the date of enactment of the Indian Health Care Improvement Act Amendments of 2009, the Secretary shall submit to Congress the current health status and resource deficiency report of the Service for each Service Unit, including newly recognized or acknowledged Indian Tribes. Such report shall set out—

''(1) the methodology then in use by the Service for determining Tribal health status and resource deficiencies, as well as the most recent application of that methodology;

''(2) the extent of the health status and resource deficiency of each Indian Tribe served by the Service or a Tribal Health Program;

''(3) the amount of funds necessary to eliminate the health status and resource deficiencies of all Indian Tribes served by the Service or a Tribal Health Program; and

''(4) an estimate of—

''(A) the amount of health service funds appropriated under the authority of this Act, or any other Act, including the amount of any funds transferred to the Service for the preceding fiscal year which is allocated to each Service Unit, Indian Tribe, or Tribal Organization;

''(B) the number of Indians eligible for health services in each Service Unit or Indian Tribe or Tribal Organization; and

''(C) the number of Indians using the Service resources made available to each Service Unit, Indian Tribe or Tribal Organization, and, to the extent available, information on the waiting lists and number of Indians turned away for services due to lack of resources.

''(g) INCLUSION IN BASE BUDGET.—Funds appropriated under this section for any fiscal year shall be included in the base budget of the Service for the purpose of determining appropriations under this section in subsequent fiscal years.

''(h) CLARIFICATION.—Nothing in this section is intended to diminish the primary responsibility of the Service to eliminate existing backlogs in unmet health care needs, nor are the provisions of this section intended to discourage the Service from undertaking additional efforts to achieve equity among Indian Tribes and Tribal Organizations.

''(i) FUNDING DESIGNATION.—Any funds appropriated under the authority of this section shall be designated as the 'Indian Health Care Improvement Fund'.

''SEC. 202. HEALTH PROMOTION AND DISEASE PREVENTION SERVICES.

''(a) FINDINGS.—Congress finds that health promotion and disease prevention activities—

''(1) improve the health and well-being of Indians; and

''(2) reduce the expenses for health care of Indians.

''(b) PROVISION OF SERVICES.—The Secretary, acting through the Service, shall provide health promotion

and disease prevention services to Indians to achieve the health status objectives set forth in section 3(2).

''(c) EVALUATION.—The Secretary, after obtaining input from the affected Tribal Health Programs, shall submit to the President for inclusion in the report which is required to be submitted to Congress under section 801 an evaluation of—

''(1) the health promotion and disease prevention needs of Indians;

''(2) the health promotion and disease prevention activities which would best meet such needs;

''(3) the internal capacity of the Service and Tribal Health Programs to meet such needs; and

''(4) the resources which would be required to enable the Service and Tribal Health Programs to undertake the health promotion and disease prevention activities necessary to meet such needs.

''SEC. 203. DIABETES PREVENTION, TREATMENT, AND CONTROL.

''(a) DETERMINATIONS REGARDING DIABETES.—The Secretary, acting through the Service, and in consultation with Indian Tribes and Tribal Organizations, shall determine—

''(1) by Indian Tribe and by Service Unit, the incidence of, and the types of complications resulting from, diabetes among Indians; and

''(2) based on the determinations made pursuant to paragraph (1), the measures (including patient education and effective ongoing monitoring of disease indicators) each Service Unit should take to reduce the incidence of, and prevent, treat, and control the complications resulting from, diabetes among Indian Tribes within that Service Unit.

''(b) DIABETES SCREENING.—To the extent medically indicated and with informed consent, the Secretary shall screen each Indian who receives services from the Service for diabetes and for conditions which indicate a high risk that the individual will become diabetic and establish a cost-effective approach to ensure ongoing monitoring of disease indicators. Such screening and monitoring may be conducted by a Tribal Health Program and may be conducted through appropriate Internet-based health care management programs.

''(c) DIABETES PROJECTS.—The Secretary shall continue to maintain each model diabetes project in existence on the date of enactment of the Indian Health Care Improvement Act Amendments of 2009.

''(d) DIALYSIS PROGRAMS.—The Secretary is authorized to provide, through the Service, Indian Tribes, and Tribal Organizations, dialysis programs, including the purchase of dialysis equipment and the provision of necessary staffing.

''(e) OTHER DUTIES OF THE SECRETARY.—

''(1) IN GENERAL.—The Secretary shall, to the extent funding is available—

''(A) in each Area Office, consult with Indian Tribes and Tribal Organizations regarding programs for the prevention, treatment, and control of diabetes;

''(B) establish in each Area Office a registry of patients with diabetes to track the incidence of diabetes and the complications from diabetes in that area; and

''(C) ensure that data collected in each Area Office regarding diabetes and related complications among Indians are disseminated to all other Area Offices, subject to applicable patient privacy laws.

''(2) DIABETES CONTROL OFFICERS.—

''(A) IN GENERAL.—The Secretary may establish and maintain in each Area Office a position of diabetes control officer to coordinate and

manage any activity of that Area Office relating to the prevention, treatment, or control of diabetes to assist the Secretary in carrying out a program under this section or section 330C of the Public Health Service Act (42 U.S.C. 254c–3).

''(B) CERTAIN ACTIVITIES.—Any activity carried out by a diabetes control officer under subparagraph (A) that is the subject of a contract or compact under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.), and any funds made available to carry out such an activity, shall not be divisible for purposes of that Act.

''SEC. 204. SHARED SERVICES FOR LONG-TERM CARE.

''(a) LONG-TERM CARE.—Notwithstanding any other provision of law, the Secretary, acting through the Service, is authorized to provide directly, or enter into contracts or compacts under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.) with Indian Tribes or Tribal Organizations for, the delivery of long-term care (including health care services associated with long-term care) provided in a facility to Indians. Such agreements shall provide for the sharing of staff or other services between the Service or a Tribal Health Program

and a long-term care or related facility owned and operated (directly or through a contract or compact under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.)) by such Indian Tribe or Tribal Organization.

''(b) CONTENTS OF AGREEMENTS.—An agreement entered into pursuant to subsection (a)—

''(1) may, at the request of the Indian Tribe or Tribal Organization, delegate to such Indian Tribe or Tribal Organization such powers of supervision and control over Service employees as the Secretary deems necessary to carry out the purposes of this section;

''(2) shall provide that expenses (including salaries) relating to services that are shared between the Service and the Tribal Health Program be allocated proportionately between the Service and the Indian Tribe or Tribal Organization; and

''(3) may authorize such Indian Tribe or Tribal Organization to construct, renovate, or expand a long-term care or other similar facility (including the construction of a facility attached to a Service facility).

''(c) MINIMUM REQUIREMENT.—Any nursing facility provided for under this section shall meet the require-

ments for nursing facilities under section 1919 of the Social Security Act.

''(d) OTHER ASSISTANCE.—The Secretary shall provide such technical and other assistance as may be necessary to enable applicants to comply with the provisions of this section.

''(e) USE OF EXISTING OR UNDERUSED FACILITIES.—The Secretary shall encourage the use of existing facilities that are underused or allow the use of swing beds for long-term or similar care.

''SEC. 205. HEALTH SERVICES RESEARCH.

''(a) IN GENERAL.—The Secretary, acting through the Service, shall make funding available for research to further the performance of the health service responsibilities of Indian Health Programs.

''(b) COORDINATION OF RESOURCES AND ACTIVITIES.—The Secretary shall also, to the maximum extent practicable, coordinate departmental research resources and activities to address relevant Indian Health Program research needs.

''(c) AVAILABILITY.—Tribal Health Programs shall be given an equal opportunity to compete for, and receive, research funds under this section.

''(d) USE OF FUNDS.—This funding may be used for both clinical and nonclinical research.

''(e) EVALUATION AND DISSEMINATION.—The Secretary shall periodically—

''(1) evaluate the impact of research conducted under this section; and

''(2) disseminate to Tribal Health Programs information regarding that research as the Secretary determines to be appropriate.

"SEC. 206. MAMMOGRAPHY AND OTHER CANCER SCREENING.

''The Secretary, acting through the Service, shall provide for screening as follows:

''(1) Screening mammography (as defined in section 1861(jj) of the Social Security Act) for Indian women at a frequency appropriate to such women under accepted and appropriate national standards, and under such terms and conditions as are consistent with standards established by the Secretary to ensure the safety and accuracy of screening mammography under part B of title XVIII of such Act.

''(2) Other cancer screening that receives an A or B rating as recommended by the United States Preventive Services Task Force established under section 915(a)(1) of the Public Health Service Act (42 U.S.C. 299b–4(a)(1)). The Secretary shall en-

sure that screening provided for under this paragraph complies with the recommendations of the Task Force with respect to—

''(A) frequency;

''(B) the population to be served;

''(C) the procedure or technology to be used;

''(D) evidence of effectiveness; and

''(E) other matters that the Secretary determines appropriate.

''SEC. 207. PATIENT TRAVEL COSTS.

''(a) DEFINITION OF QUALIFIED ESCORT.—In this section, the term 'qualified escort' means—

''(1) an adult escort (including a parent, guardian, or other family member) who is required because of the physical or mental condition, or age, of the applicable patient;

''(2) a health professional for the purpose of providing necessary medical care during travel by the applicable patient; or

''(3) other escorts, as the Secretary or applicable Indian Health Program determines to be appropriate.

''(b) PROVISION OF FUNDS.—The Secretary, acting through the Service, is authorized to provide funds for the

following patient travel costs, including qualified escorts, associated with receiving health care services provided (either through direct or contract care or through a contract or compact under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.)) under this Act—

''(1) emergency air transportation and non-emergency air transportation where ground transportation is infeasible;

''(2) transportation by private vehicle (where no other means of transportation is available), specially equipped vehicle, and ambulance; and

''(3) transportation by such other means as may be available and required when air or motor vehicle transportation is not available.

''SEC. 208. EPIDEMIOLOGY CENTERS.

''(a) ESTABLISHMENT OF CENTERS.—The Secretary shall establish an epidemiology center in each Service Area to carry out the functions described in subsection (b). Any new center established after the date of enactment of the Indian Health Care Improvement Act Amendments of 2008 may be operated under a grant authorized by subsection (d), but funding under such a grant shall not be divisible.

''(b) FUNCTIONS OF CENTERS.—In consultation with and upon the request of Indian Tribes, Tribal Organizations, and Urban Indian communities, each Service Area epidemiology center established under this section shall, with respect to such Service Area—

''(1) collect data relating to, and monitor progress made toward meeting, each of the health status objectives of the Service, the Indian Tribes, Tribal Organizations, and Urban Indian communities in the Service Area;

''(2) evaluate existing delivery systems, data systems, and other systems that impact the improvement of Indian health;

''(3) assist Indian Tribes, Tribal Organizations, and Urban Indian Organizations in identifying their highest priority health status objectives and the services needed to achieve such objectives, based on epidemiological data;

''(4) make recommendations for the targeting of services needed by the populations served;

''(5) make recommendations to improve health care delivery systems for Indians and Urban Indians;

''(6) provide requested technical assistance to Indian Tribes, Tribal Organizations, and Urban In-

dian Organizations in the development of local health service priorities and incidence and prevalence rates of disease and other illness in the community; and

''(7) provide disease surveillance and assist Indian Tribes, Tribal Organizations, and Urban Indian communities to promote public health.

''(c) TECHNICAL ASSISTANCE.—The Director of the Centers for Disease Control and Prevention shall provide technical assistance to the centers in carrying out the requirements of this section.

''(d) GRANTS FOR STUDIES.—

''(1) IN GENERAL.—The Secretary may make grants to Indian Tribes, Tribal Organizations, Indian organizations, and eligible intertribal consortia to conduct epidemiological studies of Indian communities.

''(2) ELIGIBLE INTERTRIBAL CONSORTIA.—An intertribal consortium or Indian organization is eligible to receive a grant under this subsection if—

''(A) the intertribal consortium is incorporated for the primary purpose of improving Indian health; and

''(B) the intertribal consortium is representative of the Indian Tribes or urban In-

dian communities in which the intertribal consortium is located.

''(3) APPLICATIONS.—An application for a grant under this subsection shall be submitted in such manner and at such time as the Secretary shall prescribe.

''(4) REQUIREMENTS.—An applicant for a grant under this subsection shall—

''(A) demonstrate the technical, administrative, and financial expertise necessary to carry out the functions described in paragraph (5);

''(B) consult and cooperate with providers of related health and social services in order to avoid duplication of existing services; and

''(C) demonstrate cooperation from Indian Tribes or Urban Indian Organizations in the area to be served.

''(5) USE OF FUNDS.—A grant awarded under paragraph (1) may be used—

''(A) to carry out the functions described in subsection (b);

''(B) to provide information to and consult with tribal leaders, urban Indian community

leaders, and related health staff on health care and health service management issues; and

''(C) in collaboration with Indian Tribes, Tribal Organizations, and urban Indian communities, to provide the Service with information regarding ways to improve the health status of Indians.

''(e) ACCESS TO INFORMATION.—

''(1) An epidemiology center operated by a grantee pursuant to a grant awarded under subsection (d) shall be treated as a public health authority for purposes of the Health Insurance Portability and Accountability Act of 1996, as such entities are defined in part 164.501 of title 45, Code of Federal Regulations.

''(2) The Secretary shall grant to such epidemiology center access to use of the data, data sets, monitoring systems, delivery systems, and other protected health information in the possession of the Secretary.

''(3) The activities of such an epidemiology center shall be for the purposes of research and for preventing and controlling disease, injury, or disability for purposes of the Health Insurance Portability and Accountability Act of 1996 (Public Law 104–191;

110 Stat. 2033), as such activities are described in part 164.512 of title 45, Code of Federal Regulations (or a successor regulation).

''(f) FUNDS NOT DIVISIBLE.—An epidemiology center established under this section shall be subject to the provisions of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.), but the funds for such center shall not be divisible.

''SEC. 209. COMPREHENSIVE SCHOOL HEALTH EDUCATION PROGRAMS.

''(a) FUNDING FOR DEVELOPMENT OF PROGRAMS.—In addition to carrying out any other program for health promotion or disease prevention, the Secretary, acting through the Service, is authorized to award grants to Indian Tribes and Tribal Organizations to develop comprehensive school health education programs for children from pre-school through grade 12 in schools for the benefit of Indian children.

''(b) USE OF GRANT FUNDS.—A grant awarded under this section may be used for purposes which may include, but are not limited to, the following:

''(1) Developing health education materials both for regular school programs and afterschool programs.

''(2) Training teachers in comprehensive school health education materials.

''(3) Integrating school-based, community-based, and other public and private health promotion efforts.

''(4) Encouraging healthy, tobacco-free school environments.

''(5) Coordinating school-based health programs with existing services and programs available in the community.

''(6) Developing school programs on nutrition education, personal health, oral health, and fitness.

''(7) Developing behavioral health wellness programs.

''(8) Developing chronic disease prevention programs.

''(9) Developing substance abuse prevention programs.

''(10) Developing injury prevention and safety education programs.

''(11) Developing activities for the prevention and control of communicable diseases.

''(12) Developing community and environmental health education programs that include traditional health care practitioners.

''(13) Violence prevention.

''(14) Such other health issues as are appropriate.

''(c) TECHNICAL ASSISTANCE.—Upon request, the Secretary, acting through the Service, shall provide technical assistance to Indian Tribes and Tribal Organizations in the development of comprehensive health education plans and the dissemination of comprehensive health education materials and information on existing health programs and resources.

''(d) CRITERIA FOR REVIEW AND APPROVAL OF APPLICATIONS.—The Secretary, acting through the Service, and in consultation with Indian Tribes and Tribal Organizations, shall establish criteria for the review and approval of applications for grants awarded under this section.

''(e) DEVELOPMENT OF PROGRAM FOR BIA-FUNDED SCHOOLS.—

''(1) IN GENERAL.—The Secretary of the Interior, acting through the Bureau of Indian Affairs and in cooperation with the Secretary, acting through the Service, shall develop a comprehensive school health education program for children from preschool through grade 12 in schools for which support is provided by the Bureau of Indian Affairs.

''(2) REQUIREMENTS FOR PROGRAMS.—Such programs shall include—

''(A) school programs on nutrition education, personal health, oral health, and fitness;

''(B) behavioral health wellness programs;

''(C) chronic disease prevention programs;

''(D) substance abuse prevention programs;

''(E) injury prevention and safety education programs; and

''(F) activities for the prevention and control of communicable diseases.

''(3) DUTIES OF THE SECRETARY.—The Secretary of the Interior shall—

''(A) provide training to teachers in comprehensive school health education materials;

''(B) ensure the integration and coordination of school-based programs with existing services and health programs available in the community; and

''(C) encourage healthy, tobacco-free school environments.

''SEC. 210. INDIAN YOUTH PROGRAM.

''(a) PROGRAM AUTHORIZED.—The Secretary, acting through the Service, is authorized to establish and admin-

ister a program to provide grants to Indian Tribes, Tribal Organizations, and urban Indian organizations for innovative mental and physical disease prevention and health promotion and treatment programs for Indian and urban Indian preadolescent and adolescent youths.

''(b) USE OF FUNDS.—

''(1) ALLOWABLE USES.—Funds made available under this section may be used to—

''(A) develop prevention and treatment programs for Indian youth which promote mental and physical health and incorporate cultural values, community and family involvement, and traditional health care practitioners; and

''(B) develop and provide community training and education.

''(2) PROHIBITED USE.—Funds made available under this section may not be used to provide services described in section 707(c).

''(c) DUTIES OF THE SECRETARY.—The Secretary shall—

''(1) disseminate to Indian Tribes, Tribal Organizations, and urban Indian organizations information regarding models for the delivery of comprehensive health care services to Indian and urban Indian adolescents;

''(2) encourage the implementation of such models; and

''(3) at the request of an Indian Tribe, Tribal Organization, or urban Indian organization, provide technical assistance in the implementation of such models.

''(d) CRITERIA FOR REVIEW AND APPROVAL OF APPLICATIONS.—The Secretary, in consultation with Indian Tribes, Tribal Organizations, and urban Indian organizations, shall establish criteria for the review and approval of applications or proposals under this section.

''SEC. 211. PREVENTION, CONTROL, AND ELIMINATION OF COMMUNICABLE AND INFECTIOUS DISEASES.

''(a) GRANTS AUTHORIZED.—The Secretary, acting through the Service, and after consultation with the Centers for Disease Control and Prevention, may make grants available to Indian Tribes, Tribal Organizations, and urban Indian organizations for the following:

''(1) Projects for the prevention, control, and elimination of communicable and infectious diseases, including tuberculosis, hepatitis, HIV, respiratory syncytial virus, hanta virus, sexually transmitted diseases, and H. Pylori.

''(2) Public information and education programs for the prevention, control, and elimination of communicable and infectious diseases.

''(3) Education, training, and clinical skills improvement activities in the prevention, control, and elimination of communicable and infectious diseases for health professionals, including allied health professionals.

''(4) Demonstration projects for the screening, treatment, and prevention of hepatitis C virus (HCV).

''(b) APPLICATION REQUIRED.—The Secretary may provide funding under subsection (a) only if an application or proposal for funding is submitted to the Secretary.

''(c) COORDINATION WITH HEALTH AGENCIES.—Indian Tribes, Tribal Organizations, and urban Indian organizations receiving funding under this section are encouraged to coordinate their activities with the Centers for Disease Control and Prevention and State and local health agencies.

''(d) TECHNICAL ASSISTANCE; REPORT.—In carrying out this section, the Secretary—

''(1) may, at the request of an Indian Tribe, Tribal Organization, or urban Indian organization, provide technical assistance; and

''(2) shall prepare and submit a report to Congress biennially on the use of funds under this section and on the progress made toward the prevention, control, and elimination of communicable and infectious diseases among Indians and Urban Indians.

''SEC. 212. OTHER AUTHORITY FOR PROVISION OF SERVICES.

''(a) FUNDING AUTHORIZED.—The Secretary may provide funding under this Act to meet the objectives set forth in section 3 of this Act through health care-related services and programs of the Service, Indian Tribes, and Tribal Organizations not otherwise described in this Act for the following services:

''(1) Hospice care.

''(2) Assisted living services.

''(3) Long-term care services.

''(4) Home- and community-based services.

''(b) ELIGIBILITY.—The following individuals shall be eligible to receive long-term care under this section:

''(1) Individuals who are unable to perform a certain number of activities of daily living without assistance.

''(2) Individuals with a mental impairment, such as dementia, Alzheimer's disease, or another

disabling mental illness, who may be able to perform activities of daily living under supervision.

''(3) Such other individuals as an applicable Indian Health Program determines to be appropriate.

''(c) DEFINITIONS.—For the purposes of this section, the following definitions shall apply:

''(1) The term 'assisted living services' means any service provided by an assisted living facility (as defined in section 232(b) of the National Housing Act (12 U.S.C. 1715w(b))), except that such an assisted living facility—

''(A) shall not be required to obtain a license; but

''(B) shall meet all applicable standards for licensure.

''(2) The term 'home- and community-based services' means 1 or more of the services specified in paragraphs (1) through (9) of section 1929(a) of the Social Security Act (42 U.S.C. 1396t(a)) (whether provided by the Service or by an Indian Tribe or Tribal Organization pursuant to the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.)) that are or will be provided in accordance with applicable standards.

''(3) The term 'hospice care' means the items and services specified in subparagraphs (A) through (H) of section 1861(dd)(1) of the Social Security Act (42 U.S.C. 1395x(dd)(1)), and such other services which an Indian Tribe or Tribal Organization determines are necessary and appropriate to provide in furtherance of this care.

''(4) The term 'long-term care services' has the meaning given the term 'qualified long-term care services' in section 7702B(c) of the Internal Revenue Code of 1986.

''(d) AUTHORIZATION OF CONVENIENT CARE SERVICES.—The Secretary, acting through the Service, Indian Tribes, and Tribal Organizations, may also provide funding under this Act to meet the objectives set forth in section 3 of this Act for convenient care services programs pursuant to section 306(c)(2)(A).

''SEC. 213. INDIAN WOMEN'S HEALTH CARE.

''The Secretary, acting through the Service and Indian Tribes, Tribal Organizations, and Urban Indian Organizations, shall monitor and improve the quality of health care for Indian women of all ages through the planning and delivery of programs administered by the Service, in order to improve and enhance the treatment models of care for Indian women.

"SEC. 214. ENVIRONMENTAL AND NUCLEAR HEALTH HAZARDS.

''(a) STUDIES AND MONITORING.—The Secretary and the Service shall conduct, in conjunction with other appropriate Federal agencies and in consultation with concerned Indian Tribes and Tribal Organizations, studies and ongoing monitoring programs to determine trends in the health hazards to Indian miners and to Indians on or near reservations and Indian communities as a result of environmental hazards which may result in chronic or life threatening health problems, such as nuclear resource development, petroleum contamination, and contamination of water source and of the food chain. Such studies shall include—

''(1) an evaluation of the nature and extent of health problems caused by environmental hazards currently exhibited among Indians and the causes of such health problems;

''(2) an analysis of the potential effect of ongoing and future environmental resource development on or near reservations and Indian communities, including the cumulative effect over time on health;

''(3) an evaluation of the types and nature of activities, practices, and conditions causing or affecting such health problems, including uranium mining and milling, uranium mine tailing deposits, nuclear

power plant operation and construction, and nuclear waste disposal; oil and gas production or transportation on or near reservations or Indian communities; and other development that could affect the health of Indians and their water supply and food chain;

''(4) a summary of any findings and recommendations provided in Federal and State studies, reports, investigations, and inspections during the 5 years prior to the date of enactment of the Indian Health Care Improvement Act Amendments of 2009 that directly or indirectly relate to the activities, practices, and conditions affecting the health or safety of such Indians; and

''(5) the efforts that have been made by Federal and State agencies and resource and economic development companies to effectively carry out an education program for such Indians regarding the health and safety hazards of such development.

''(b) HEALTH CARE PLANS.—Upon completion of such studies, the Secretary and the Service shall take into account the results of such studies and develop health care plans to address the health problems studied under subsection (a). The plans shall include—

''(1) methods for diagnosing and treating Indians currently exhibiting such health problems;

''(2) preventive care and testing for Indians who may be exposed to such health hazards, including the monitoring of the health of individuals who have or may have been exposed to excessive amounts of radiation or affected by other activities that have had or could have a serious impact upon the health of such individuals; and

''(3) a program of education for Indians who, by reason of their work or geographic proximity to such nuclear or other development activities, may experience health problems.

''(c) SUBMISSION OF REPORT AND PLAN TO CONGRESS.—The Secretary and the Service shall submit to Congress the study prepared under subsection (a) no later than 18 months after the date of enactment of the Indian Health Care Improvement Act Amendments of 2009. The health care plan prepared under subsection (b) shall be submitted in a report no later than 1 year after the study prepared under subsection (a) is submitted to Congress. Such report shall include recommended activities for the implementation of the plan, as well as an evaluation of any activities previously undertaken by the Service to address such health problems.

''(d) INTERGOVERNMENTAL TASK FORCE.—

''(1) ESTABLISHMENT; MEMBERS.—There is established an Intergovernmental Task Force to be composed of the following individuals (or their designees):

''(A) The Secretary of Energy.

''(B) The Secretary of the Environmental Protection Agency.

''(C) The Director of the Bureau of Mines.

''(D) The Assistant Secretary for Occupational Safety and Health.

''(E) The Secretary of the Interior.

''(F) The Secretary of Health and Human Services.

''(G) The Director of the Indian Health Service.

''(2) DUTIES.—The Task Force shall—

''(A) identify existing and potential operations related to nuclear resource development or other environmental hazards that affect or may affect the health of Indians on or near a reservation or in an Indian community; and

''(B) enter into activities to correct existing health hazards and ensure that current and future health problems resulting from nuclear

resource or other development activities are minimized or reduced.

''(3) CHAIRMAN; MEETINGS.—The Secretary of Health and Human Services shall be the Chairman of the Task Force. The Task Force shall meet at least twice each year.

''(e) HEALTH SERVICES TO CERTAIN EMPLOYEES.—In the case of any Indian who—

''(1) as a result of employment in or near a uranium mine or mill or near any other environmental hazard, suffers from a work-related illness or condition;

''(2) is eligible to receive diagnosis and treatment services from an Indian Health Program; and

''(3) by reason of such Indian's employment, is entitled to medical care at the expense of such mine or mill operator or entity responsible for the environmental hazard, the Indian Health Program shall, at the request of such Indian, render appropriate medical care to such Indian for such illness or condition and may be reimbursed for any medical care so rendered to which such Indian is entitled at the expense of such operator or entity from such operator or entity. Nothing in this subsection shall affect the rights of such Indian to recover damages other than

such amounts paid to the Indian Health Program from the employer for providing medical care for such illness or condition.

"SEC. 215. ARIZONA AS A CONTRACT HEALTH SERVICE DELIVERY AREA.

"(a) IN GENERAL.—For fiscal years beginning with the fiscal year ending September 30, 1983, and ending with the fiscal year ending September 30, 2025, the State of Arizona shall be designated as a contract health service delivery area by the Service for the purpose of providing contract health care services to members of federally recognized Indian Tribes of Arizona.

"(b) MAINTENANCE OF SERVICES.—The Service shall not curtail any health care services provided to Indians residing on reservations in the State of Arizona if such curtailment is due to the provision of contract services in such State pursuant to the designation of such State as a contract health service delivery area pursuant to subsection (a).

"SEC. 216. NORTH DAKOTA AND SOUTH DAKOTA AS CONTRACT HEALTH SERVICE DELIVERY AREA.

"(a) IN GENERAL.—Beginning in fiscal year 2003, the States of North Dakota and South Dakota shall be designated as a contract health service delivery area by the Service for the purpose of providing contract health

care services to members of federally recognized Indian Tribes of North Dakota and South Dakota.

''(b) LIMITATION.—The Service shall not curtail any health care services provided to Indians residing on any reservation, or in any county that has a common boundary with any reservation, in the State of North Dakota or South Dakota if such curtailment is due to the provision of contract services in such States pursuant to the designation of such States as a contract health service delivery area pursuant to subsection (a).

''SEC. 217. CALIFORNIA CONTRACT HEALTH SERVICES PROGRAM.

''(a) FUNDING AUTHORIZED.—The Secretary is authorized to fund a program using the California Rural Indian Health Board (hereafter in this section referred to as the 'CRIHB') as a contract care intermediary to improve the accessibility of health services to California Indians.

''(b) REIMBURSEMENT CONTRACT.—The Secretary shall enter into an agreement with the CRIHB to reimburse the CRIHB for costs (including reasonable administrative costs) incurred pursuant to this section, in providing medical treatment under contract to California Indians described in section 805(a) throughout the Cali-

fornia contract health services delivery area described in section 219 with respect to high cost contract care cases.

''(c) ADMINISTRATIVE EXPENSES.—Not more than 5 percent of the amounts provided to the CRIHB under this section for any fiscal year may be for reimbursement for administrative expenses incurred by the CRIHB during such fiscal year.

''(d) LIMITATION ON PAYMENT.—No payment may be made for treatment provided hereunder to the extent payment may be made for such treatment under the Indian Catastrophic Health Emergency Fund described in section 202 or from amounts appropriated or otherwise made available to the California contract health service delivery area for a fiscal year.

''(e) ADVISORY BOARD.—There is established an advisory board which shall advise the CRIHB in carrying out this section. The advisory board shall be composed of representatives, selected by the CRIHB, from not less than 8 Tribal Health Programs serving California Indians covered under this section at least ½ of whom of whom are not affiliated with the CRIHB.

''SEC. 218. CALIFORNIA AS A CONTRACT HEALTH SERVICE DELIVERY AREA.

''The State of California, excluding the counties of Alameda, Contra Costa, Los Angeles, Marin, Orange, Sac-

ramento, San Francisco, San Mateo, Santa Clara, Kern, Merced, Monterey, Napa, San Benito, San Joaquin, San Luis Obispo, Santa Cruz, Solano, Stanislaus, and Ventura, shall be designated as a contract health service delivery area by the Service for the purpose of providing contract health services to California Indians. However, any of the counties listed herein may only be included in the contract health services delivery area if funding is specifically provided by the Service for such services in those counties.

"SEC. 219. CONTRACT HEALTH SERVICES FOR THE TRENTON SERVICE AREA.

''(a) AUTHORIZATION FOR SERVICES.—The Secretary, acting through the Service, is directed to provide contract health services to members of the Turtle Mountain Band of Chippewa Indians that reside in the Trenton Service Area of Divide, McKenzie, and Williams counties in the State of North Dakota and the adjoining counties of Richland, Roosevelt, and Sheridan in the State of Montana.

''(b) NO EXPANSION OF ELIGIBILITY.—Nothing in this section may be construed as expanding the eligibility of members of the Turtle Mountain Band of Chippewa Indians for health services provided by the Service beyond

the scope of eligibility for such health services that applied on May 1, 1986.

"SEC. 220. PROGRAMS OPERATED BY INDIAN TRIBES AND TRIBAL ORGANIZATIONS.

''The Service shall provide funds for health care programs, functions, services, activities, information technology, and facilities operated by Tribal Health Programs on the same basis as such funds are provided to programs, functions, services, activities, information technology, and facilities operated directly by the Service.

"SEC. 221. LICENSING.

''Licensed health care professionals employed by a Tribal Health Program shall, if licensed in any State, be exempt from the licensing requirements of the State in which the Tribal Health Program performs the services described in its contract or compact under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.) while performing such services.

"SEC. 222. NOTIFICATION OF PROVISION OF EMERGENCY CONTRACT HEALTH SERVICES.

''With respect to an elderly Indian or an Indian with a disability receiving emergency medical care or services from a non-Service provider or in a non-Service facility under the authority of this Act, the time limitation (as

a condition of payment) for notifying the Service of such treatment or admission shall be 30 days.

"SEC. 223. PROMPT ACTION ON PAYMENT OF CLAIMS.

''(a) DEADLINE FOR RESPONSE.—The Service shall respond to a notification of a claim by a provider of a contract care service with either an individual purchase order or a denial of the claim within 5 working days after the receipt of such notification.

''(b) EFFECT OF UNTIMELY RESPONSE.—If the Service fails to respond to a notification of a claim in accordance with subsection (a), the Service shall accept as valid the claim submitted by the provider of a contract care service.

''(c) DEADLINE FOR PAYMENT OF VALID CLAIM.—The Service shall pay a valid contract care service claim within 30 days after the completion of the claim.

"SEC. 224. LIABILITY FOR PAYMENT.

''(a) NO PATIENT LIABILITY.—A patient who receives contract health care services that are authorized by the Service shall not be liable for the payment of any charges or costs associated with the provision of such services.

''(b) NOTIFICATION.—The Secretary shall notify a contract care provider and any patient who receives contract health care services authorized by the Service that

such patient is not liable for the payment of any charges or costs associated with the provision of such services not later than 5 business days after receipt of a notification of a claim by a provider of contract care services.

''(c) NO RECOURSE.—Following receipt of the notice provided under subsection (b), or, if a claim has been deemed accepted under section 224(b), the provider shall have no further recourse against the patient who received the services.

''SEC. 225. OFFICE OF INDIAN MEN'S HEALTH.

''(a) ESTABLISHMENT.—The Secretary may establish within the Service an office to be known as the 'Office of Indian Men's Health' (referred to in this section as the 'Office').

''(b) DIRECTOR.—

''(1) IN GENERAL.—The Office shall be headed by a director, to be appointed by the Secretary.

''(2) DUTIES.—The director shall coordinate and promote the status of the health of Indian men in the United States.

''(c) REPORT.—Not later than 2 years after the date of enactment of the Indian Health Care Improvement Act Amendments of 2009, the Secretary, acting through the director of the Office, shall submit to Congress a report describing—

''(1) any activity carried out by the director as of the date on which the report is prepared; and

''(2) any finding of the director with respect to the health of Indian men.

''SEC. 226. CATASTROPHIC HEALTH EMERGENCY FUND.

''(a) ESTABLISHMENT.—There is established an Indian Catastrophic Health Emergency Fund (hereafter in this section referred to as the 'CHEF') consisting of—

''(1) the amounts deposited under subsection (f); and

''(2) the amounts appropriated to CHEF under this section.

''(b) ADMINISTRATION.—CHEF shall be administered by the Secretary, acting through the headquarters of the Service, solely for the purpose of meeting the extraordinary medical costs associated with the treatment of victims of disasters or catastrophic illnesses who are within the responsibility of the Service.

''(c) CONDITIONS ON USE OF FUND.—No part of CHEF or its administration shall be subject to contract or grant under any law, including the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.), nor shall CHEF funds be allocated, apportioned, or delegated on an Area Office, Service Unit, or other similar basis.

''(d) REGULATIONS.—The Secretary shall promulgate regulations consistent with the provisions of this section to—

''(1) establish a definition of disasters and catastrophic illnesses for which the cost of the treatment provided under contract would qualify for payment from CHEF;

''(2) provide that a Service Unit shall not be eligible for reimbursement for the cost of treatment from CHEF until its cost of treating any victim of such catastrophic illness or disaster has reached a certain threshold cost which the Secretary shall establish at—

''(A) the 2000 level of $19,000; and

''(B) for any subsequent year, not less than the threshold cost of the previous year increased by the percentage increase in the medical care expenditure category of the consumer price index for all urban consumers (United States city average) for the 12-month period ending with December of the previous year;

''(3) establish a procedure for the reimbursement of the portion of the costs that exceeds such threshold cost incurred by—

''(A) Service Units; or

''(B) whenever otherwise authorized by the Service, non-Service facilities or providers;

''(4) establish a procedure for payment from CHEF in cases in which the exigencies of the medical circumstances warrant treatment prior to the authorization of such treatment by the Service; and

''(5) establish a procedure that will ensure that no payment shall be made from CHEF to any provider of treatment to the extent that such provider is eligible to receive payment for the treatment from any other Federal, State, local, or private source of reimbursement for which the patient is eligible.

''(e) NO OFFSET OR LIMITATION.—Amounts appropriated to CHEF under this section shall not be used to offset or limit appropriations made to the Service under the authority of the Act of November 2, 1921 (25 U.S.C. 13) (commonly known as the 'Snyder Act'), or any other law.

''(f) DEPOSIT OF REIMBURSEMENT FUNDS.—There shall be deposited into CHEF all reimbursements to which the Service is entitled from any Federal, State, local, or private source (including third party insurance) by reason of treatment rendered to any victim of a disaster or catastrophic illness the cost of which was paid from CHEF.

''SEC. 227. AUTHORIZATION OF APPROPRIATIONS.

''There are authorized to be appropriated such sums as may be necessary to carry out this title.

''TITLE III—FACILITIES

''SEC. 301. CONSULTATION; CONSTRUCTION AND RENOVATION OF FACILITIES; REPORTS.

''(a) PREREQUISITES FOR EXPENDITURE OF FUNDS.—Prior to the expenditure of, or the making of any binding commitment to expend, any funds appropriated for the planning, design, construction, or renovation of facilities pursuant to the Act of November 2, 1921 (25 U.S.C. 13) (commonly known as the 'Snyder Act'), the Secretary, acting through the Service, shall—

''(1) consult with any Indian Tribe that would be significantly affected by such expenditure for the purpose of determining and, whenever practicable, honoring tribal preferences concerning size, location, type, and other characteristics of any facility on which such expenditure is to be made; and

''(2) ensure, whenever practicable and applicable, that such facility meets the construction standards of any accrediting body recognized by the Secretary for the purposes of the Medicare, Medicaid, and SCHIP programs under titles XVIII, XIX, and XXI of the Social Security Act by not later than 1

year after the date on which the construction or renovation of such facility is completed.

''(b) CLOSURES.—

''(1) EVALUATION REQUIRED.—Notwithstanding any other provision of law, no facility operated by the Service may be closed if the Secretary has not submitted to Congress, not less than 1 year and not more than 2 years before the date of the proposed closure, an evaluation, completed not more than 2 years before such submission, of the impact of the proposed closure that specifies, in addition to other considerations—

''(A) the accessibility of alternative health care resources for the population served by such facility;

''(B) the cost-effectiveness of such closure;

''(C) the quality of health care to be provided to the population served by such facility after such closure;

''(D) the availability of contract health care funds to maintain existing levels of service;

''(E) the views of the Indian Tribes served by such facility concerning such closure;

''(F) the level of use of such facility by all eligible Indians; and

''(G) the distance between such facility and the nearest operating Service hospital.

''(2) EXCEPTION FOR CERTAIN TEMPORARY CLOSURES.—Paragraph (1) shall not apply to any temporary closure of a facility or any portion of a facility if such closure is necessary for medical, environmental, or construction safety reasons.

''(c) HEALTH CARE FACILITY PRIORITY SYSTEM.—

''(1) IN GENERAL.—

''(A) PRIORITY SYSTEM.—The Secretary, acting through the Service, shall maintain a health care facility priority system, which—

''(i) shall be developed in consultation with Indian Tribes and Tribal Organizations;

''(ii) shall give Indian Tribes' needs the highest priority;

''(iii)(I) may include the lists required in paragraph (2)(B)(ii); and

''(II) shall include the methodology required in paragraph (2)(B)(v); and

''(III) may include such other facilities, and such renovation or expansion needs of any health care facility, as the

Service, Indian Tribes, and Tribal Organizations may identify; and

''(iv) shall provide an opportunity for the nomination of planning, design, and construction projects by the Service, Indian Tribes, and Tribal Organizations for consideration under the priority system at least once every 3 years, or more frequently as the Secretary determines to be appropriate.

''(B) NEEDS OF FACILITIES UNDER ISDEAA AGREEMENTS.—The Secretary shall ensure that the planning, design, construction, renovation, and expansion needs of Service and non-Service facilities operated under contracts or compacts in accordance with the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.) are fully and equitably integrated into the health care facility priority system.

''(C) CRITERIA FOR EVALUATING NEEDS.—For purposes of this subsection, the Secretary, in evaluating the needs of facilities operated under a contract or compact under the Indian Self-Determination and Education As-

sistance Act (25 U.S.C. 450 et seq.), shall use the criteria used by the Secretary in evaluating the needs of facilities operated directly by the Service.

''(D) PRIORITY OF CERTAIN PROJECTS PROTECTED.—The priority of any project established under the construction priority system in effect on the date of enactment of the Indian Health Care Improvement Act Amendments of 2009 shall not be affected by any change in the construction priority system taking place after that date if the project—

''(i) was identified in the fiscal year 2008 Service budget justification as—

''(I) 1 of the 10 top-priority inpatient projects;

''(II) 1 of the 10 top-priority outpatient projects;

''(III) 1 of the 10 top-priority staff quarters developments; or

''(IV) 1 of the 10 top-priority Youth Regional Treatment Centers;

''(ii) had completed both Phase I and Phase II of the construction priority sys-

tem in effect on the date of enactment of such Act; or

''(iii) is not included in clause (i) or (ii) and is selected, as determined by the Secretary—

''(I) on the initiative of the Secretary; or

''(II) pursuant to a request of an Indian Tribe or Tribal Organization.

''(2) REPORT; CONTENTS.—

''(A) INITIAL COMPREHENSIVE REPORT.—

''(i) DEFINITIONS.—In this subparagraph:

''(I) FACILITIES APPROPRIATION ADVISORY BOARD.—The term 'Facilities Appropriation Advisory Board' means the advisory board, comprised of 12 members representing Indian tribes and 2 members representing the Service, established at the discretion of the Assistant Secretary—

''(aa) to provide advice and recommendations for policies and procedures of the programs fund-

ed pursuant to facilities appropriations; and

''(bb) to address other facilities issues.

''(II) FACILITIES NEEDS ASSESSMENT WORKGROUP.—The term 'Facilities Needs Assessment Workgroup' means the workgroup established at the discretion of the Assistant Secretary—

''(aa) to review the health care facilities construction priority system; and

''(bb) to make recommendations to the Facilities Appropriation Advisory Board for revising the priority system.

''(ii) INITIAL REPORT.—

''(I) IN GENERAL.—Not later than 1 year after the date of enactment of the Indian Health Care Improvement Act Amendments of 2009, the Secretary shall submit to the Committee on Indian Affairs of the Senate and the Committee on Natural

Resources of the House of Representatives a report that describes the comprehensive, national, ranked list of all health care facilities needs for the Service, Indian Tribes, and Tribal Organizations (including inpatient health care facilities, outpatient health care facilities, specialized health care facilities (such as for long-term care and alcohol and drug abuse treatment), wellness centers, staff quarters and hostels associated with health care facilities, and the renovation and expansion needs, if any, of such facilities) developed by the Service, Indian Tribes, and Tribal Organizations for the Facilities Needs Assessment Workgroup and the Facilities Appropriation Advisory Board.

''(II) INCLUSIONS.—The initial report shall include—

''(aa) the methodology and criteria used by the Service in determining the needs and estab-

lishing the ranking of the facilities needs; and

''(bb) such other information as the Secretary determines to be appropriate.

''(iii) UPDATES OF REPORT.—Beginning in calendar year 2011, the Secretary shall—

''(I) update the report under clause (ii) not less frequently that once every 5 years; and

''(II) include the updated report in the appropriate annual report under subparagraph (B) for submission to Congress under section 801.

''(B) ANNUAL REPORTS.—The Secretary shall submit to the President, for inclusion in the report required to be transmitted to Congress under section 801, a report which sets forth the following:

''(i) A description of the health care facility priority system of the Service established under paragraph (1).

''(ii) Health care facilities lists, which may include—

''(I) the 10 top-priority inpatient health care facilities;

''(II) the 10 top-priority outpatient health care facilities;

''(III) the 10 top-priority specialized health care facilities (such as long-term care and alcohol and drug abuse treatment);

''(IV) the 10 top-priority staff quarters developments associated with health care facilities; and

''(V) the 10 top-priority hostels associated with health care facilities.

''(iii) The justification for such order of priority.

''(iv) The projected cost of such projects.

''(v) The methodology adopted by the Service in establishing priorities under its health care facility priority system.

''(3) REQUIREMENTS FOR PREPARATION OF REPORTS.—In preparing the report required under paragraph (2), the Secretary shall—

''(A) consult with and obtain information on all health care facilities needs from Indian

Tribes, Tribal Organizations, and urban Indian organizations; and

''(B) review the total unmet needs of all Indian Tribes, Tribal Organizations, and urban Indian organizations for health care facilities (including hostels and staff quarters), including needs for renovation and expansion of existing facilities.

''(d) REVIEW OF METHODOLOGY USED FOR HEALTH FACILITIES CONSTRUCTION PRIORITY SYSTEM.—

''(1) IN GENERAL.—Not later than 1 year after the establishment of the priority system under subsection (c)(1)(A), the Comptroller General of the United States shall prepare and finalize a report reviewing the methodologies applied, and the processes followed, by the Service in making each assessment of needs for the list under subsection (c)(2)(A)(ii) and developing the priority system under subsection (c)(1), including a review of—

''(A) the recommendations of the Facilities Appropriation Advisory Board and the Facilities Needs Assessment Workgroup (as those terms are defined in subsection (c)(2)(A)(i)); and

''(B) the relevant criteria used in ranking or prioritizing facilities other than hospitals or clinics.

''(2) SUBMISSION TO CONGRESS.—The Comptroller General of the United States shall submit the report under paragraph (1) to—

''(A) the Committees on Indian Affairs and Appropriations of the Senate;

''(B) the Committees on Natural Resources and Appropriations of the House of Representatives; and

''(C) the Secretary.

''(e) FUNDING CONDITION.—All funds appropriated under the Act of November 2, 1921 (25 U.S.C. 13) (commonly known as the 'Snyder Act'), for the planning, design, construction, or renovation of health facilities for the benefit of 1 or more Indian Tribes shall be subject to the provisions of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.).

''(f) DEVELOPMENT OF INNOVATIVE APPROACHES.—The Secretary shall consult and cooperate with Indian Tribes, Tribal Organizations, and urban Indian organizations in developing innovative approaches to address all or part of the total unmet need for construction of health

facilities, including those provided for in other sections of this title and other approaches.

"SEC. 302. SANITATION FACILITIES.

''(a) FINDINGS.—Congress finds the following:

''(1) The provision of sanitation facilities is primarily a health consideration and function.

''(2) Indian people suffer an inordinately high incidence of disease, injury, and illness directly attributable to the absence or inadequacy of sanitation facilities.

''(3) The long-term cost to the United States of treating and curing such disease, injury, and illness is substantially greater than the short-term cost of providing sanitation facilities and other preventive health measures.

''(4) Many Indian homes and Indian communities still lack sanitation facilities.

''(5) It is in the interest of the United States, and it is the policy of the United States, that all Indian communities and Indian homes, new and existing, be provided with sanitation facilities.

''(b) FACILITIES AND SERVICES.—In furtherance of the findings made in subsection (a), Congress reaffirms the primary responsibility and authority of the Service to provide the necessary sanitation facilities and services as

provided in section 7 of the Act of August 5, 1954 (42 U.S.C. 2004a). Under such authority, the Secretary, acting through the Service, is authorized to provide the following:

''(1) Financial and technical assistance to Indian Tribes, Tribal Organizations, and Indian communities in the establishment, training, and equipping of utility organizations to operate and maintain sanitation facilities, including the provision of existing plans, standard details, and specifications available in the Department, to be used at the option of the Indian Tribe, Tribal Organization, or Indian community.

''(2) Ongoing technical assistance and training to Indian Tribes, Tribal Organizations, and Indian communities in the management of utility organizations which operate and maintain sanitation facilities.

''(3) Priority funding for operation and maintenance assistance for, and emergency repairs to, sanitation facilities operated by an Indian Tribe, Tribal Organization or Indian community when necessary to avoid an imminent health threat or to protect the investment in sanitation facilities and the investment

in the health benefits gained through the provision of sanitation facilities.

''(c) FUNDING.—Notwithstanding any other provision of law—

''(1) the Secretary of Housing and Urban Development is authorized to transfer funds appropriated under the Native American Housing Assistance and Self-Determination Act of 1996 (25 U.S.C. 4101 et seq.) to the Secretary of Health and Human Services;

''(2) the Secretary of Health and Human Services is authorized to accept and use such funds for the purpose of providing sanitation facilities and services for Indians under section 7 of the Act of August 5, 1954 (42 U.S.C. 2004a);

''(3) unless specifically authorized when funds are appropriated, the Secretary shall not use funds appropriated under section 7 of the Act of August 5, 1954 (42 U.S.C. 2004a), to provide sanitation facilities to new homes constructed using funds provided by the Department of Housing and Urban Development;

''(4) the Secretary of Health and Human Services is authorized to accept from any source, including Federal and State agencies, funds for the pur-

pose of providing sanitation facilities and services and place these funds into contracts or compacts under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.);

''(5) except as otherwise prohibited by this section, the Secretary may use funds appropriated under the authority of section 7 of the Act of August 5, 1954 (42 U.S.C. 2004a), to fund up to 100 percent of the amount of an Indian Tribe's loan obtained under any Federal program for new projects to construct eligible sanitation facilities to serve Indian homes;

''(6) except as otherwise prohibited by this section, the Secretary may use funds appropriated under the authority of section 7 of the Act of August 5, 1954 (42 U.S.C. 2004a), to meet matching or cost participation requirements under other Federal and non-Federal programs for new projects to construct eligible sanitation facilities;

''(7) all Federal agencies are authorized to transfer to the Secretary funds identified, granted, loaned, or appropriated whereby the Department's applicable policies, rules, and regulations shall apply in the implementation of such projects;

''(8) the Secretary of Health and Human Services shall enter into interagency agreements with Federal and State agencies for the purpose of providing financial assistance for sanitation facilities and services under this Act;

''(9) the Secretary of Health and Human Services shall, by regulation, establish standards applicable to the planning, design, and construction of sanitation facilities funded under this Act; and

''(10) the Secretary of Health and Human Services is authorized to accept payments for goods and services furnished by the Service from appropriate public authorities, nonprofit organizations or agencies, or Indian Tribes, as contributions by that authority, organization, agency, or tribe to agreements made under section 7 of the Act of August 5, 1954 (42 U.S.C. 2004a), and such payments shall be credited to the same or subsequent appropriation account as funds appropriated under the authority of section 7 of the Act of August 5, 1954 (42 U.S.C. 2004a).

''(d) CERTAIN CAPABILITIES NOT PREREQUISITE.—The financial and technical capability of an Indian Tribe, Tribal Organization, or Indian community to safely operate, manage, and maintain a sanitation facility shall not

be a prerequisite to the provision or construction of sanitation facilities by the Secretary.

''(e) FINANCIAL ASSISTANCE.—The Secretary is authorized to provide financial assistance to Indian Tribes, Tribal Organizations, and Indian communities in an amount equal to the Federal share of the costs of operating, managing, and maintaining the facilities provided under the plan described in subsection (h)(1)(F).

''(f) OPERATION, MANAGEMENT, AND MAINTENANCE OF FACILITIES.—The Indian Tribe has the primary responsibility to establish, collect, and use reasonable user fees, or otherwise set aside funding, for the purpose of operating, managing, and maintaining sanitation facilities. If a sanitation facility serving a community that is operated by an Indian Tribe or Tribal Organization is threatened with imminent failure and such operator lacks capacity to maintain the integrity or the health benefits of the sanitation facility, then the Secretary is authorized to assist the Indian Tribe, Tribal Organization, or Indian community in the resolution of the problem on a short-term basis through cooperation with the emergency coordinator or by providing operation, management, and maintenance service.

''(g) ISDEAA PROGRAM FUNDED ON EQUAL BASIS.—Tribal Health Programs shall be eligible (on an

equal basis with programs that are administered directly by the Service) for—

''(1) any funds appropriated pursuant to this section; and

''(2) any funds appropriated for the purpose of providing sanitation facilities.

''(h) REPORT.—

''(1) REQUIRED; CONTENTS.—The Secretary, in consultation with the Secretary of Housing and Urban Development, Indian Tribes, Tribal Organizations, and tribally designated housing entities (as defined in section 4 of the Native American Housing Assistance and Self-Determination Act of 1996 (25 U.S.C. 4103)) shall submit to the President, for inclusion in the report required to be transmitted to Congress under section 801, a report which sets forth—

''(A) the current Indian sanitation facility priority system of the Service;

''(B) the methodology for determining sanitation deficiencies and needs;

''(C) the criteria on which the deficiencies and needs will be evaluated;

''(D) the level of initial and final sanitation deficiency for each type of sanitation facility for

each project of each Indian Tribe or Indian community;

''(E) the amount and most effective use of funds, derived from whatever source, necessary to accommodate the sanitation facilities needs of new homes assisted with funds under the Native American Housing Assistance and Self-Determination Act (25 U.S.C. 4101 et seq.), and to reduce the identified sanitation deficiency levels of all Indian Tribes and Indian communities to level I sanitation deficiency as defined in paragraph (3)(A); and

''(F) a 10-year plan to provide sanitation facilities to serve existing Indian homes and Indian communities and new and renovated Indian homes.

''(2) UNIFORM METHODOLOGY.—The methodology used by the Secretary in determining, preparing cost estimates for, and reporting sanitation deficiencies for purposes of paragraph (1) shall be applied uniformly to all Indian Tribes and Indian communities.

''(3) SANITATION DEFICIENCY LEVELS.—For purposes of this subsection, the sanitation deficiency levels for an individual, Indian Tribe, or Indian com-

munity sanitation facility to serve Indian homes are determined as follows:

''(A) A level I deficiency exists if a sanitation facility serving an individual, Indian Tribe, or Indian community—

''(i) complies with all applicable water supply, pollution control, and solid waste disposal laws; and

''(ii) deficiencies relate to routine replacement, repair, or maintenance needs.

''(B) A level II deficiency exists if a sanitation facility serving an individual, Indian Tribe, or Indian community substantially or recently complied with all applicable water supply, pollution control, and solid waste laws and any deficiencies relate to—

''(i) small or minor capital improvements needed to bring the facility back into compliance;

''(ii) capital improvements that are necessary to enlarge or improve the facilities in order to meet the current needs for domestic sanitation facilities; or

''(iii) the lack of equipment or training by an Indian Tribe, Tribal Organiza-

tion, or an Indian community to properly operate and maintain the sanitation facilities.

''(C) A level III deficiency exists if a sanitation facility serving an individual, Indian Tribe or Indian community meets 1 or more of the following conditions—

''(i) water or sewer service in the home is provided by a haul system with holding tanks and interior plumbing;

''(ii) major significant interruptions to water supply or sewage disposal occur frequently, requiring major capital improvements to correct the deficiencies; or

''(iii) there is no access to or no approved or permitted solid waste facility available.

''(D) A level IV deficiency exists—

''(i) if a sanitation facility for an individual home, an Indian Tribe, or an Indian community exists but—

''(I) lacks—

''(aa) a safe water supply system; or

''(bb) a waste disposal system;

''(II) contains no piped water or sewer facilities; or

''(III) has become inoperable due to a major component failure; or

''(ii) if only a washeteria or central facility exists in the community.

''(E) A level V deficiency exists in the absence of a sanitation facility, where individual homes do not have access to safe drinking water or adequate wastewater (including sewage) disposal.

''(i) DEFINITIONS.—For purposes of this section, the following terms apply:

''(1) INDIAN COMMUNITY.—The term 'Indian community' means a geographic area, a significant proportion of whose inhabitants are Indians and which is served by or capable of being served by a facility described in this section.

''(2) SANITATION FACILITIES.—The terms 'sanitation facility' and 'sanitation facilities' mean safe and adequate water supply systems, sanitary sewage disposal systems, and sanitary solid waste

systems (and all related equipment and support infrastructure).

"SEC. 303. PREFERENCE TO INDIANS AND INDIAN FIRMS.

"(a) BUY INDIAN ACT.—The Secretary, acting through the Service, may use the negotiating authority of section 23 of the Act of June 25, 1910 (25 U.S.C. 47, commonly known as the 'Buy Indian Act'), to give preference to any Indian or any enterprise, partnership, corporation, or other type of business organization owned and controlled by an Indian or Indians including former or currently federally recognized Indian Tribes in the State of New York (hereinafter referred to as an 'Indian firm') in the construction and renovation of Service facilities pursuant to section 301 and in the construction of sanitation facilities pursuant to section 302. Such preference may be accorded by the Secretary unless the Secretary finds, pursuant to regulations, that the project or function to be contracted for will not be satisfactory or such project or function cannot be properly completed or maintained under the proposed contract. The Secretary, in arriving at such a finding, shall consider whether the Indian or Indian firm will be deficient with respect to—

"(1) ownership and control by Indians;

"(2) equipment;

"(3) bookkeeping and accounting procedures;

''(4) substantive knowledge of the project or function to be contracted for;

''(5) adequately trained personnel; or

''(6) other necessary components of contract performance.

''(b) PAY RATES.—For the purposes of implementing the provisions of this title, the Secretary shall assure that the rates of pay for personnel engaged in the construction or renovation of facilities constructed or renovated in whole or in part by funds made available pursuant to this title are not less than the prevailing local wage rates for similar work as determined in accordance with the Act of March 3, 1931 (40 U.S.C. 276a–276a-5, known as the Davis-Bacon Act).

''(c) LABOR STANDARDS.—For the purposes of implementing the provisions of this title, contracts for the construction or renovation of health care facilities, staff quarters, and sanitation facilities, and related support infrastructure, funded in whole or in part with funds made available pursuant to this title, shall contain a provision requiring compliance with subchapter IV of chapter 31 of title 40, United States Code (commonly known as the 'Davis-Bacon Act').

"SEC. 304. EXPENDITURE OF NON-SERVICE FUNDS FOR RENOVATION.

''(a) IN GENERAL.—Notwithstanding any other provision of law, if the requirements of subsection (c) are met, the Secretary, acting through the Service, is authorized to accept any major expansion, renovation, or modernization by any Indian Tribe or Tribal Organization of any Service facility or of any other Indian health facility operated pursuant to a contract or compact under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.), including—

''(1) any plans or designs for such expansion, renovation, or modernization; and

''(2) any expansion, renovation, or modernization for which funds appropriated under any Federal law were lawfully expended.

''(b) PRIORITY LIST.—

''(1) IN GENERAL.—The Secretary shall maintain a separate priority list to address the needs for increased operating expenses, personnel, or equipment for such facilities. The methodology for establishing priorities shall be developed through regulations. The list of priority facilities will be revised annually in consultation with Indian Tribes and Tribal Organizations.

''(2) REPORT.—The Secretary shall submit to the President, for inclusion in the report required to be transmitted to Congress under section 801, the priority list maintained pursuant to paragraph (1).

''(c) REQUIREMENTS.—The requirements of this subsection are met with respect to any expansion, renovation, or modernization if—

''(1) the Indian Tribe or Tribal Organization—

''(A) provides notice to the Secretary of its intent to expand, renovate, or modernize; and

''(B) applies to the Secretary to be placed on a separate priority list to address the needs of such new facilities for increased operating expenses, personnel, or equipment; and

''(2) the expansion, renovation, or modernization—

''(A) is approved by the appropriate area director of the Service for Federal facilities; and

''(B) is administered by the Indian Tribe or Tribal Organization in accordance with any applicable regulations prescribed by the Secretary with respect to construction or renovation of Service facilities.

''(d) ADDITIONAL REQUIREMENT FOR EXPANSION.—In addition to the requirements under subsection (c), for

any expansion, the Indian Tribe or Tribal Organization shall provide to the Secretary additional information pursuant to regulations, including additional staffing, equipment, and other costs associated with the expansion.

''(e) CLOSURE OR CONVERSION OF FACILITIES.—If any Service facility which has been expanded, renovated, or modernized by an Indian Tribe or Tribal Organization under this section ceases to be used as a Service facility during the 20-year period beginning on the date such expansion, renovation, or modernization is completed, such Indian Tribe or Tribal Organization shall be entitled to recover from the United States an amount which bears the same ratio to the value of such facility at the time of such cessation as the value of such expansion, renovation, or modernization (less the total amount of any funds provided specifically for such facility under any Federal program that were expended for such expansion, renovation, or modernization) bore to the value of such facility at the time of the completion of such expansion, renovation, or modernization.

''SEC. 305. FUNDING FOR THE CONSTRUCTION, EXPANSION, AND MODERNIZATION OF SMALL AMBULATORY CARE FACILITIES.

''(a) GRANTS.—

''(1) IN GENERAL.—The Secretary, acting through the Service, shall make grants to Indian Tribes and Tribal Organizations for the construction, expansion, or modernization of facilities for the provision of ambulatory care services to eligible Indians (and noneligible persons pursuant to subsections (b)(2) and (c)(1)(C)). A grant made under this section may cover up to 100 percent of the costs of such construction, expansion, or modernization. For the purposes of this section, the term 'construction' includes the replacement of an existing facility.

''(2) GRANT AGREEMENT REQUIRED.—A grant under paragraph (1) may only be made available to a Tribal Health Program operating an Indian health facility (other than a facility owned or constructed by the Service, including a facility originally owned or constructed by the Service and transferred to an Indian Tribe or Tribal Organization).

''(b) USE OF GRANT FUNDS.—

''(1) ALLOWABLE USES.—A grant awarded under this section may be used for the construction, expansion, or modernization (including the planning and design of such construction, expansion, or modernization) of an ambulatory care facility—

''(A) located apart from a hospital;

''(B) not funded under section 301 or section 306; and

''(C) which, upon completion of such construction or modernization will—

''(i) have a total capacity appropriate to its projected service population;

''(ii) provide annually no fewer than 150 patient visits by eligible Indians and other users who are eligible for services in such facility in accordance with section 806(c)(2); and

''(iii) provide ambulatory care in a Service Area (specified in the contract or compact under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.)) with a population of no fewer than 1,500 eligible Indians and other users who are eligible for services in such facility in accordance with section 806(c)(2).

''(2) ADDITIONAL ALLOWABLE USE.—The Secretary may also reserve a portion of the funding provided under this section and use those reserved funds to reduce an outstanding debt incurred by Indian Tribes or Tribal Organizations for the con-

struction, expansion, or modernization of an ambulatory care facility that meets the requirements under paragraph (1). The provisions of this section shall apply, except that such applications for funding under this paragraph shall be considered separately from applications for funding under paragraph (1).

''(3) USE ONLY FOR CERTAIN PORTION OF COSTS.—A grant provided under this section may be used only for the cost of that portion of a construction, expansion, or modernization project that benefits the Service population identified above in subsection (b)(1)(C) (ii) and (iii). The requirements of clauses (ii) and (iii) of paragraph (1)(C) shall not apply to an Indian Tribe or Tribal Organization applying for a grant under this section for a health care facility located or to be constructed on an island or when such facility is not located on a road system providing direct access to an inpatient hospital where care is available to the Service population.

''(c) GRANTS.—

''(1) APPLICATION.—No grant may be made under this section unless an application or proposal for the grant has been approved by the Secretary in accordance with applicable regulations and has set

forth reasonable assurance by the applicant that, at all times after the construction, expansion, or modernization of a facility carried out using a grant received under this section—

''(A) adequate financial support will be available for the provision of services at such facility;

''(B) such facility will be available to eligible Indians without regard to ability to pay or source of payment; and

''(C) such facility will, as feasible without diminishing the quality or quantity of services provided to eligible Indians, serve noneligible persons on a cost basis.

''(2) PRIORITY.—In awarding grants under this section, the Secretary shall give priority to Indian Tribes and Tribal Organizations that demonstrate—

''(A) a need for increased ambulatory care services; and

''(B) insufficient capacity to deliver such services.

''(3) PEER REVIEW PANELS.—The Secretary may provide for the establishment of peer review panels, as necessary, to review and evaluate applications and proposals and to advise the Secretary re-

garding such applications using the criteria developed pursuant to subsection (a)(1).

''(d) REVERSION OF FACILITIES.—If any facility (or portion thereof) with respect to which funds have been paid under this section, ceases, at any time after completion of the construction, expansion, or modernization carried out with such funds, to be used for the purposes of providing health care services to eligible Indians, all of the right, title, and interest in and to such facility (or portion thereof) shall transfer to the United States unless otherwise negotiated by the Service and the Indian Tribe or Tribal Organization.

''(e) FUNDING NONRECURRING.—Funding provided under this section shall be nonrecurring and shall not be available for inclusion in any individual Indian Tribe's tribal share for an award under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.) or for reallocation or redesign thereunder.

''SEC. 306. INDIAN HEALTH CARE DELIVERY DEMONSTRATION PROJECT.

''(a) HEALTH CARE DEMONSTRATION PROJECTS.—The Secretary, acting through the Service, is authorized to make grants to, and enter into construction contracts or construction project agreements with, Indian Tribes or Tribal Organizations under the Indian Self-Determination

and Education Assistance Act (25 U.S.C. 450 et seq.) for the purpose of carrying out a health care delivery demonstration project to test alternative means of delivering health care and services to Indians through facilities.

''(b) USE OF FUNDS.—The Secretary, in approving projects pursuant to this section, may authorize such contracts for the construction and renovation of hospitals, health centers, health stations, and other facilities to deliver health care services and is authorized to—

''(1) waive any leasing prohibition;

''(2) permit carryover of funds appropriated for the provision of health care services;

''(3) permit the use of other available funds;

''(4) permit the use of funds or property donated from any source for project purposes;

''(5) provide for the reversion of donated real or personal property to the donor; and

''(6) permit the use of Service funds to match other funds, including Federal funds.

''(c) REGULATIONS.—The Secretary shall develop and promulgate regulations, not later than 1 year after the date of enactment of the Indian Health Care Improvement Act Amendments of 2009, for the review and approval of applications submitted under this section.

''(d) CRITERIA.—The Secretary may approve projects that meet the following criteria:

''(1) There is a need for a new facility or program or the reorientation of an existing facility or program.

''(2) A significant number of Indians, including those with low health status, will be served by the project.

''(3) The project has the potential to deliver services in an efficient and effective manner.

''(4) The project is economically viable.

''(5) The Indian Tribe or Tribal Organization has the administrative and financial capability to administer the project.

''(6) The project is integrated with providers of related health and social services and is coordinated with, and avoids duplication of, existing services.

''(e) PEER REVIEW PANELS.—The Secretary may provide for the establishment of peer review panels, as necessary, to review and evaluate applications using the criteria developed pursuant to subsection (d).

''(f) PRIORITY.—The Secretary shall give priority to applications for demonstration projects in each of the following Service Units to the extent that such applications

are timely filed and meet the criteria specified in subsection (d):

''(1) Cass Lake, Minnesota.

''(2) Mescalero, New Mexico.

''(3) Owyhee, Nevada.

''(4) Schurz, Nevada.

''(5) Ft. Yuma, California.

''(g) TECHNICAL ASSISTANCE.—The Secretary shall provide such technical and other assistance as may be necessary to enable applicants to comply with the provisions of this section.

''(h) SERVICE TO INELIGIBLE PERSONS.—Subject to section 806, the authority to provide services to persons otherwise ineligible for the health care benefits of the Service and the authority to extend hospital privileges in Service facilities to non-Service health practitioners as provided in section 806 may be included, subject to the terms of such section, in any demonstration project approved pursuant to this section.

''(i) EQUITABLE TREATMENT.—For purposes of subsection (d)(1), the Secretary shall, in evaluating facilities operated under any contract or compact under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.), use the same criteria that the Sec-

retary uses in evaluating facilities operated directly by the Service.

''(j) EQUITABLE INTEGRATION OF FACILITIES.—The Secretary shall ensure that the planning, design, construction, renovation, and expansion needs of Service and non-Service facilities which are the subject of a contract or compact under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.) for health services are fully and equitably integrated into the implementation of the health care delivery demonstration projects under this section.

''SEC. 307. LAND TRANSFER.

''Notwithstanding any other provision of law, the Bureau of Indian Affairs and all other agencies and departments of the United States are authorized to transfer, at no cost, land and improvements to the Service for the provision of health care services. The Secretary is authorized to accept such land and improvements for such purposes.

''SEC. 308. LEASES, CONTRACTS, AND OTHER AGREEMENTS.

''The Secretary, acting through the Service, may enter into leases, contracts, and other agreements with Indian Tribes and Tribal Organizations which hold (1) title to, (2) a leasehold interest in, or (3) a beneficial interest in (when title is held by the United States in trust for the benefit of an Indian Tribe) facilities used or to be used

for the administration and delivery of health services by an Indian Health Program. Such leases, contracts, or agreements may include provisions for construction or renovation and provide for compensation to the Indian Tribe or Tribal Organization of rental and other costs consistent with section 105(l) of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450j(l)) and regulations thereunder.

"SEC. 309. STUDY ON LOANS, LOAN GUARANTEES, AND LOAN REPAYMENT.

''(a) IN GENERAL.—The Secretary, in consultation with the Secretary of the Treasury, Indian Tribes, and Tribal Organizations, shall carry out a study to determine the feasibility of establishing a loan fund to provide to Indian Tribes and Tribal Organizations direct loans or guarantees for loans for the construction of health care facilities, including—

''(1) inpatient facilities;

''(2) outpatient facilities;

''(3) staff quarters;

''(4) hostels; and

''(5) specialized care facilities, such as behavioral health and elder care facilities.

''(b) DETERMINATIONS.—In carrying out the study under subsection (a), the Secretary shall determine—

''(1) the maximum principal amount of a loan or loan guarantee that should be offered to a recipient from the loan fund;

''(2) the percentage of eligible costs, not to exceed 100 percent, that may be covered by a loan or loan guarantee from the loan fund (including costs relating to planning, design, financing, site land development, construction, rehabilitation, renovation, conversion, improvements, medical equipment and furnishings, and other facility-related costs and capital purchase (but excluding staffing));

''(3) the cumulative total of the principal of direct loans and loan guarantees, respectively, that may be outstanding at any 1 time;

''(4) the maximum term of a loan or loan guarantee that may be made for a facility from the loan fund;

''(5) the maximum percentage of funds from the loan fund that should be allocated for payment of costs associated with planning and applying for a loan or loan guarantee;

''(6) whether acceptance by the Secretary of an assignment of the revenue of an Indian Tribe or Tribal Organization as security for any direct loan

or loan guarantee from the loan fund would be appropriate;

''(7) whether, in the planning and design of health facilities under this section, users eligible under section 806(c) may be included in any projection of patient population;

''(8) whether funds of the Service provided through loans or loan guarantees from the loan fund should be eligible for use in matching other Federal funds under other programs;

''(9) the appropriateness of, and best methods for, coordinating the loan fund with the health care priority system of the Service under section 301; and

''(10) any legislative or regulatory changes required to implement recommendations of the Secretary based on results of the study.

''(c) REPORT.—Not later than September 30, 2010, the Secretary shall submit to the Committee on Indian Affairs of the Senate and the Committee on Natural Resources and the Committee on Energy and Commerce of the House of Representatives a report that describes—

''(1) the manner of consultation made as required by subsection (a); and

''(2) the results of the study, including any recommendations of the Secretary based on results of the study.

"SEC. 310. TRIBAL LEASING.

''A Tribal Health Program may lease permanent structures for the purpose of providing health care services without obtaining advance approval in appropriation Acts.

"SEC. 311. INDIAN HEALTH SERVICE/TRIBAL FACILITIES JOINT VENTURE PROGRAM.

''(a) IN GENERAL.—The Secretary, acting through the Service, shall make arrangements with Indian Tribes and Tribal Organizations to establish joint venture demonstration projects under which an Indian Tribe or Tribal Organization shall expend tribal, private, or other available funds, for the acquisition or construction of a health facility for a minimum of 10 years, under a no-cost lease, in exchange for agreement by the Service to provide the equipment, supplies, and staffing for the operation and maintenance of such a health facility. An Indian Tribe or Tribal Organization may use tribal funds, private sector, or other available resources, including loan guarantees, to fulfill its commitment under a joint venture entered into under this subsection. An Indian Tribe or Tribal Organization shall be eligible to establish a joint venture project if, when it submits a letter of intent, it—

''(1) has begun but not completed the process of acquisition or construction of a health facility to be used in the joint venture project;

''(2) has not begun the process of acquisition or construction of a health facility for use in the joint venture project; or

''(3) in its application for a joint venture agreement, agrees—

''(A) to construct a facility for the joint venture which complies with the size and space criteria established by the Service; or

''(B) if the facility it proposes for the joint venture is already in existence or under construction, that only the portion of such facility which complies with the size and space criteria of the Service will be eligible for the joint venture agreement.

''(b) REQUIREMENTS.—The Secretary shall make such an arrangement with an Indian Tribe or Tribal Organization only if—

''(1) the Secretary first determines that the Indian Tribe or Tribal Organization has the administrative and financial capabilities necessary to complete the timely acquisition or construction of the relevant health facility; and

''(2) the Indian Tribe or Tribal Organization meets the need criteria determined using the criteria developed under the health care facility priority system under section 301, unless the Secretary determines, pursuant to regulations, that other criteria will result in a more cost-effective and efficient method of facilitating and completing construction of health care facilities.

''(c) CONTINUED OPERATION.—The Secretary shall negotiate an agreement with the Indian Tribe or Tribal Organization regarding the continued operation of the facility at the end of the initial 10 year no-cost lease period.

''(d) BREACH OF AGREEMENT.—An Indian Tribe or Tribal Organization that has entered into a written agreement with the Secretary under this section, and that breaches or terminates without cause such agreement, shall be liable to the United States for the amount that has been paid to the Indian Tribe or Tribal Organization, or paid to a third party on the Indian Tribe's or Tribal Organization's behalf, under the agreement. The Secretary has the right to recover tangible property (including supplies) and equipment, less depreciation, and any funds expended for operations and maintenance under this section. The preceding sentence does not apply to any funds

expended for the delivery of health care services, personnel, or staffing.

''(e) RECOVERY FOR NONUSE.—An Indian Tribe or Tribal Organization that has entered into a written agreement with the Secretary under this subsection shall be entitled to recover from the United States an amount that is proportional to the value of such facility if, at any time within the 10-year term of the agreement, the Service ceases to use the facility or otherwise breaches the agreement.

''(f) DEFINITION.—For the purposes of this section, the term 'health facility' or 'health facilities' includes quarters needed to provide housing for staff of the relevant Tribal Health Program.

''SEC. 312. LOCATION OF FACILITIES.

''(a) IN GENERAL.—In all matters involving the reorganization or development of Service facilities or in the establishment of related employment projects to address unemployment conditions in economically depressed areas, the Bureau of Indian Affairs and the Service shall give priority to locating such facilities and projects on Indian lands, or lands in Alaska owned by any Alaska Native village, or village or regional corporation under the Alaska Native Claims Settlement Act (43 U.S.C. 1601 et seq.), or any land allotted to any Alaska Native, if requested

by the Indian owner and the Indian Tribe with jurisdiction over such lands or other lands owned or leased by the Indian Tribe or Tribal Organization. Top priority shall be given to Indian land owned by 1 or more Indian Tribes.

''(b) DEFINITION.—For purposes of this section, the term 'Indian lands' means—

''(1) all lands within the exterior boundaries of any reservation; and

''(2) any lands title to which is held in trust by the United States for the benefit of any Indian Tribe or individual Indian or held by any Indian Tribe or individual Indian subject to restriction by the United States against alienation.

''SEC. 313. MAINTENANCE AND IMPROVEMENT OF HEALTH CARE FACILITIES.

''(a) REPORT.—The Secretary shall submit to the President, for inclusion in the report required to be transmitted to Congress under section 801, a report which identifies the backlog of maintenance and repair work required at both Service and tribal health care facilities, including new health care facilities expected to be in operation in the next fiscal year. The report shall also identify the need for renovation and expansion of existing facilities to support the growth of health care programs.

''(b) MAINTENANCE OF NEWLY CONSTRUCTED SPACE.—The Secretary, acting through the Service, is authorized to expend maintenance and improvement funds to support maintenance of newly constructed space only if such space falls within the approved supportable space allocation for the Indian Tribe or Tribal Organization. Supportable space allocation shall be defined through the health care facility priority system under section 301(c).

''(c) REPLACEMENT FACILITIES.—In addition to using maintenance and improvement funds for renovation, modernization, and expansion of facilities, an Indian Tribe or Tribal Organization may use maintenance and improvement funds for construction of a replacement facility if the costs of renovation of such facility would exceed a maximum renovation cost threshold. The Secretary shall consult with Indian Tribes and Tribal Organizations in determining the maximum renovation cost threshold.

''SEC. 314. TRIBAL MANAGEMENT OF FEDERALLY OWNED QUARTERS.

''(a) RENTAL RATES.—

''(1) ESTABLISHMENT.—Notwithstanding any other provision of law, a Tribal Health Program which operates a hospital or other health facility and the federally owned quarters associated therewith pursuant to a contract or compact under the Indian

Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.) shall have the authority to establish the rental rates charged to the occupants of such quarters by providing notice to the Secretary of its election to exercise such authority.

''(2) OBJECTIVES.—In establishing rental rates pursuant to authority of this subsection, a Tribal Health Program shall endeavor to achieve the following objectives:

''(A) To base such rental rates on the reasonable value of the quarters to the occupants thereof.

''(B) To generate sufficient funds to prudently provide for the operation and maintenance of the quarters, and subject to the discretion of the Tribal Health Program, to supply reserve funds for capital repairs and replacement of the quarters.

''(3) EQUITABLE FUNDING.—Any quarters whose rental rates are established by a Tribal Health Program pursuant to this subsection shall remain eligible for quarters improvement and repair funds to the same extent as all federally owned quarters used to house personnel in Services-supported programs.

''(4) NOTICE OF RATE CHANGE.—A Tribal Health Program which exercises the authority provided under this subsection shall provide occupants with no less than 60 days notice of any change in rental rates.

''(b) DIRECT COLLECTION OF RENT.—

''(1) IN GENERAL.—Notwithstanding any other provision of law, and subject to paragraph (2), a Tribal Health Program shall have the authority to collect rents directly from Federal employees who occupy such quarters in accordance with the following:

''(A) The Tribal Health Program shall notify the Secretary and the subject Federal employees of its election to exercise its authority to collect rents directly from such Federal employees.

''(B) Upon receipt of a notice described in subparagraph (A), the Federal employees shall pay rents for occupancy of such quarters directly to the Tribal Health Program and the Secretary shall have no further authority to collect rents from such employees through payroll deduction or otherwise.

''(C) Such rent payments shall be retained by the Tribal Health Program and shall not be

made payable to or otherwise be deposited with the United States.

''(D) Such rent payments shall be deposited into a separate account which shall be used by the Tribal Health Program for the maintenance (including capital repairs and replacement) and operation of the quarters and facilities as the Tribal Health Program shall determine.

''(2) RETROCESSION OF AUTHORITY.—If a Tribal Health Program which has made an election under paragraph (1) requests retrocession of its authority to directly collect rents from Federal employees occupying federally owned quarters, such retrocession shall become effective on the earlier of—

''(A) the first day of the month that begins no less than 180 days after the Tribal Health Program notifies the Secretary of its desire to retrocede; or

''(B) such other date as may be mutually agreed by the Secretary and the Tribal Health Program.

''(c) RATES IN ALASKA.—To the extent that a Tribal Health Program, pursuant to authority granted in subsection (a), establishes rental rates for federally owned

quarters provided to a Federal employee in Alaska, such rents may be based on the cost of comparable private rental housing in the nearest established community with a year-round population of 1,500 or more individuals.

"SEC. 315. APPLICABILITY OF BUY AMERICAN ACT REQUIREMENT.

''(a) APPLICABILITY.—The Secretary shall ensure that the requirements of the Buy American Act apply to all procurements made with funds provided pursuant to section 317. Indian Tribes and Tribal Organizations shall be exempt from these requirements.

''(b) EFFECT OF VIOLATION.—If it has been finally determined by a court or Federal agency that any person intentionally affixed a label bearing a 'Made in America' inscription or any inscription with the same meaning, to any product sold in or shipped to the United States that is not made in the United States, such person shall be ineligible to receive any contract or subcontract made with funds provided pursuant to section 317, pursuant to the debarment, suspension, and ineligibility procedures described in sections 9.400 through 9.409 of title 48, Code of Federal Regulations.

''(c) DEFINITIONS.—For purposes of this section, the term 'Buy American Act' means title III of the Act entitled 'An Act making appropriations for the Treasury and

Post Office Departments for the fiscal year ending June 30, 1934, and for other purposes', approved March 3, 1933 (41 U.S.C. 10a et seq.).

"SEC. 316. OTHER FUNDING FOR FACILITIES.

''(a) AUTHORITY TO ACCEPT FUNDS.—The Secretary is authorized to accept from any source, including Federal and State agencies, funds that are available for the construction of health care facilities and use such funds to plan, design, and construct health care facilities for Indians and to place such funds into a contract or compact under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.). Receipt of such funds shall have no effect on the priorities established pursuant to section 301.

''(b) INTERAGENCY AGREEMENTS.—The Secretary is authorized to enter into interagency agreements with other Federal agencies or State agencies and other entities and to accept funds from such Federal or State agencies or other sources to provide for the planning, design, and construction of health care facilities to be administered by Indian Health Programs in order to carry out the purposes of this Act and the purposes for which the funds were appropriated or for which the funds were otherwise provided.

''(c) TRANSFERRED FUNDS.—Any Federal agency to which funds for the construction of health care facilities are appropriated is authorized to transfer such funds to the Secretary for the construction of health care facilities to carry out the purposes of this Act as well as the purposes for which such funds are appropriated to such other Federal agency.

''(d) ESTABLISHMENT OF STANDARDS.—The Secretary, through the Service, shall establish standards by regulation for the planning, design, and construction of health care facilities serving Indians under this Act.

"SEC. 317. AUTHORIZATION OF APPROPRIATIONS.

''There are authorized to be appropriated such sums as may be necessary to carry out this title.

"TITLE IV—ACCESS TO HEALTH SERVICES

"SEC. 401. TREATMENT OF PAYMENTS UNDER SOCIAL SECURITY ACT HEALTH BENEFITS PROGRAMS.

''(a) DISREGARD OF MEDICARE, MEDICAID, AND SCHIP PAYMENTS IN DETERMINING APPROPRIATIONS.—Any payments received by an Indian Health Program or by an urban Indian organization under title XVIII, XIX, or XXI of the Social Security Act for services provided to Indians eligible for benefits under such respective titles

shall not be considered in determining appropriations for the provision of health care and services to Indians.

''(b) NONPREFERENTIAL TREATMENT.—Nothing in this Act authorizes the Secretary to provide services to an Indian with coverage under title XVIII, XIX, or XXI of the Social Security Act in preference to an Indian without such coverage.

''(c) USE OF FUNDS.—

''(1) SPECIAL FUND.—

''(A) 100 PERCENT PASS-THROUGH OF PAYMENTS DUE TO FACILITIES.—Notwithstanding any other provision of law, but subject to paragraph (2), payments to which a facility of the Service is entitled by reason of a provision of title XVIII or XIX of the Social Security Act shall be placed in a special fund to be held by the Secretary. In making payments from such fund, the Secretary shall ensure that each Service Unit of the Service receives 100 percent of the amount to which the facilities of the Service, for which such Service Unit makes collections, are entitled by reason of a provision of either such title.

''(B) USE OF FUNDS.—Amounts received by a facility of the Service under subparagraph

(A) by reason of a provision of title XVIII or XIX of the Social Security Act shall first be used (to such extent or in such amounts as are provided in appropriation Acts) for the purpose of making any improvements in the programs of the Service operated by or through such facility which may be necessary to achieve or maintain compliance with the applicable conditions and requirements of such respective title. Any amounts so received that are in excess of the amount necessary to achieve or maintain such conditions and requirements shall, subject to consultation with the Indian Tribes being served by the Service Unit, be used for increasing the facility's capacity to provide, or improving the quality or accessibility of, services.

''(2) DIRECT PAYMENT OPTION.—Paragraph (1) shall not apply to a Tribal Health Program upon the election of such Program under subsection (d) to receive payments directly. No payment may be made out of the special fund described in such paragraph with respect to reimbursement made for services provided by such Program during the period of such election.

''(d) DIRECT BILLING.—

''(1) IN GENERAL.—Subject to complying with the requirements of paragraph (2), a Tribal Health Program may elect to directly bill for, and receive payment for, health care items and services provided by such Program for which payment is made under title XVIII, XIX, or XXI of the Social Security Act.

''(2) DIRECT REIMBURSEMENT.—

''(A) USE OF FUNDS.—Each Tribal Health Program making the election described in paragraph (1) with respect to a program under title XVIII, XIX, or XXI of the Social Security Act shall be reimbursed directly by that program for items and services furnished without regard to subsection (c)(1), but all amounts so reimbursed shall be used by the Tribal Health Program for the same purposes with respect to such Program for which payment under subparagraph (A) of subsection (c)(1) to a facility of the Service may be used pursuant to subparagraph (B) of such subsection with respect to the Service.

''(B) AUDITS.—The amounts paid to a Tribal Health Program making the election described in paragraph (1) with respect to a program under title XVIII, XIX, or XXI of the So-

cial Security Act shall be subject to all auditing requirements applicable to the program under such title, as well as all auditing requirements applicable to programs administered by an Indian Health Program. Nothing in the preceding sentence shall be construed as limiting the application of auditing requirements applicable to amounts paid under title XVIII, XIX, or XXI of the Social Security Act.

''(C) IDENTIFICATION OF SOURCE OF PAYMENTS.—Any Tribal Health Program that receives reimbursements or payments under title XVIII, XIX, or XXI of the Social Security Act shall provide to the Service a list of each provider enrollment number (or other identifier) under which such Program receives such reimbursements or payments.

''(3) EXAMINATION AND IMPLEMENTATION OF CHANGES.—

''(A) IN GENERAL.—The Secretary, acting through the Service and with the assistance of the Administrator of the Centers for Medicare & Medicaid Services, shall examine on an ongoing basis and implement any administrative changes that may be necessary to facilitate di-

rect billing and reimbursement under the program established under this subsection, including any agreements with States that may be necessary to provide for direct billing under a program under title XIX or XXI of the Social Security Act.

''(B) COORDINATION OF INFORMATION.—The Service shall provide the Administrator of the Centers for Medicare & Medicaid Services with copies of the lists submitted to the Service under paragraph (2)(C), enrollment data regarding patients served by the Service (and by Tribal Health Programs, to the extent such data is available to the Service), and such other information as the Administrator may require for purposes of administering title XVIII, XIX, or XXI of the Social Security Act.

''(4) WITHDRAWAL FROM PROGRAM.—A Tribal Health Program that bills directly under the program established under this subsection may withdraw from participation in the same manner and under the same conditions that an Indian Tribe or Tribal Organization may retrocede a contracted program to the Secretary under the authority of the Indian Self-Determination and Education Assistance

Act (25 U.S.C. 450 et seq.). All cost accounting and billing authority under the program established under this subsection shall be returned to the Secretary upon the Secretary's acceptance of the withdrawal of participation in this program.

''(5) TERMINATION FOR FAILURE TO COMPLY WITH REQUIREMENTS.—The Secretary may terminate the participation of a Tribal Health Program or in the direct billing program established under this subsection if the Secretary determines that the Program has failed to comply with the requirements of paragraph (2). The Secretary shall provide a Tribal Health Program with notice of a determination that the Program has failed to comply with any such requirement and a reasonable opportunity to correct such noncompliance prior to terminating the Program's participation in the direct billing program established under this subsection.

''(e) RELATED PROVISIONS UNDER THE SOCIAL SECURITY ACT.—For provisions related to subsections (c) and (d), see sections 1880, 1911, and 2107(e)(1)(D) of the Social Security Act.

"SEC. 402. GRANTS TO AND CONTRACTS WITH THE SERVICE, INDIAN TRIBES, TRIBAL ORGANIZATIONS, AND URBAN INDIAN ORGANIZATIONS TO FACILITATE OUTREACH, ENROLLMENT, AND COVERAGE OF INDIANS UNDER SOCIAL SECURITY ACT HEALTH BENEFIT PROGRAMS.

''(a) INDIAN TRIBES AND TRIBAL ORGANIZATIONS.—The Secretary, acting through the Service, shall make grants to or enter into contracts with Indian Tribes and Tribal Organizations to assist such Tribes and Tribal Organizations in establishing and administering programs on or near reservations, trust lands, and Alaska Native Villages, including programs to provide outreach and enrollment through video, electronic delivery methods, or telecommunication devices that allow real-time or time-delayed communication between individual Indians and the benefit program, to assist individual Indians—

''(1) to enroll for benefits under a program established under title XVIII, XIX, or XXI of the Social Security Act; and

''(2) with respect to such programs for which the charging of premiums and cost sharing is not prohibited under such programs, to pay premiums or cost sharing for coverage for such benefits, which may be based on financial need (as determined by the Indian Tribe or Tribes or Tribal Organizations

being served based on a schedule of income levels developed or implemented by such Tribe, Tribes, or Tribal Organizations).

''(b) CONDITIONS.—The Secretary, acting through the Service, shall place conditions as deemed necessary to effect the purpose of this section in any grant or contract which the Secretary makes with any Indian Tribe or Tribal Organization pursuant to this section. Such conditions shall include requirements that the Indian Tribe or Tribal Organization successfully undertake—

''(1) to determine the population of Indians eligible for the benefits described in subsection (a);

''(2) to educate Indians with respect to the benefits available under the respective programs;

''(3) to provide transportation for such individual Indians to the appropriate offices for enrollment or applications for such benefits; and

''(4) to develop and implement methods of improving the participation of Indians in receiving benefits under such programs.

''(c) APPLICATION TO URBAN INDIAN ORGANIZATIONS.—

''(1) IN GENERAL.—The provisions of subsection (a) shall apply with respect to grants and other funding to urban Indian organizations with re-

spect to populations served by such organizations in the same manner they apply to grants and contracts with Indian Tribes and Tribal Organizations with respect to programs on or near reservations.

''(2) REQUIREMENTS.—The Secretary shall include in the grants or contracts made or provided under paragraph (1) requirements that are—

''(A) consistent with the requirements imposed by the Secretary under subsection (b);

''(B) appropriate to urban Indian organizations and urban Indians; and

''(C) necessary to effect the purposes of this section.

''(d) FACILITATING COOPERATION IN ENROLLMENT AND RETENTION.—The Secretary, acting through the Centers for Medicare & Medicaid Services, shall consult with States, the Service, Indian Tribes, Tribal Organizations, and urban Indian organizations to develop and disseminate best practices with respect to facilitating agreements between the States and Indian Tribes, Tribal Organizations, and urban Indian organizations relating to enrollment and retention of Indians in programs established under titles XVIII, XIX, and XXI of the Social Security Act.

''(e) AGREEMENTS TO IMPROVE ENROLLMENT OF INDIANS UNDER SOCIAL SECURITY ACT HEALTH BENEFITS PROGRAMS.—For provisions relating to agreements between the Secretary and the Service, Indian Tribes, Tribal Organizations, and urban Indian organizations for the collection, preparation, and submission of applications by Indians for assistance under the Medicaid and children's health insurance programs established under titles XIX and XXI of the Social Security Act, and benefits under the Medicare program established under title XVIII of such Act, see subsections (a) and (b) of section 1139 of the Social Security Act.

''(f) DEFINITIONS.—In this section:

''(1) PREMIUM.—The term 'premium' includes any enrollment fee or similar charge.

''(2) COST SHARING.—The term 'cost sharing' includes any deduction, deductible, copayment, coinsurance, or similar charge.

''(3) BENEFITS.—The term 'benefits' means, with respect to—

''(A) title XVIII of the Social Security Act, benefits under such title;

''(B) title XIX of such Act, medical assistance under such title; and

''(C) title XXI of such Act, assistance under such title.

"SEC. 403. REIMBURSEMENT FROM CERTAIN THIRD PARTIES OF COSTS OF HEALTH SERVICES.

''(a) RIGHT OF RECOVERY.—Except as provided in subsection (f), the United States, an Indian Tribe, or Tribal Organization shall have the right to recover from an insurance company, health maintenance organization, employee benefit plan, third-party tortfeasor, or any other responsible or liable third party (including a political subdivision or local governmental entity of a State) the reasonable charges incurred by the Secretary, an Indian Tribe, or Tribal Organization, or, if higher, the highest amount the third party would pay for care and services furnished by providers other than governmental entities, in providing health services through the Service, an Indian Tribe, or Tribal Organization to any individual to the same extent that such individual, or any nongovernmental provider of such services, would be eligible to receive damages, reimbursement, or indemnification for such charges if—

''(1) such services had been provided by a nongovernmental provider; and

''(2) such individual had been required to pay such charges or expenses and did pay such charges or expenses.

''(b) LIMITATIONS ON RECOVERIES FROM STATES.—Subsection (a) shall provide a right of recovery against any State, only if the injury, illness, or disability for which health services were provided is covered under—

''(1) workers' compensation laws; or

''(2) a no-fault automobile accident insurance plan or program.

''(c) NONAPPLICATION OF OTHER LAWS.—No law of any State, or of any political subdivision of a State and no provision of any contract, insurance or health maintenance organization policy, employee benefit plan, self-insurance plan, managed care plan, or other health care plan or program entered into or renewed after the date of the enactment of the Indian Health Care Amendments of 1988, shall prevent or hinder the right of recovery of the United States, an Indian Tribe, or Tribal Organization under subsection (a).

''(d) NO EFFECT ON PRIVATE RIGHTS OF ACTION.—No action taken by the United States, an Indian Tribe, or Tribal Organization to enforce the right of recovery provided under this section shall operate to deny to the

injured person the recovery for that portion of the person's damage not covered hereunder.

''(e) ENFORCEMENT.—

''(1) IN GENERAL.—The United States, an Indian Tribe, or Tribal Organization may enforce the right of recovery provided under subsection (a) by—

''(A) intervening or joining in any civil action or proceeding brought—

''(i) by the individual for whom health services were provided by the Secretary, an Indian Tribe, or Tribal Organization; or

''(ii) by any representative or heirs of such individual, or

''(B) instituting a civil action, including a civil action for injunctive relief and other relief and including, with respect to a political subdivision or local governmental entity of a State, such an action against an official thereof.

''(2) NOTICE.—All reasonable efforts shall be made to provide notice of action instituted under paragraph (1)(B) to the individual to whom health services were provided, either before or during the pendency of such action.

''(3) RECOVERY FROM TORTFEASORS.—

''(A) IN GENERAL.—In any case in which an Indian Tribe or Tribal Organization that is authorized or required under a compact or contract issued pursuant to the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.) to furnish or pay for health services to a person who is injured or suffers a disease on or after the date of enactment of the Indian Health Care Improvement Act Amendments of 2009 under circumstances that establish grounds for a claim of liability against the tortfeasor with respect to the injury or disease, the Indian Tribe or Tribal Organization shall have a right to recover from the tortfeasor (or an insurer of the tortfeasor) the reasonable value of the health services so furnished, paid for, or to be paid for, in accordance with the Federal Medical Care Recovery Act (42 U.S.C. 2651 et seq.), to the same extent and under the same circumstances as the United States may recover under that Act.

''(B) TREATMENT.—The right of an Indian Tribe or Tribal Organization to recover under subparagraph (A) shall be independent of the rights of the injured or diseased person

served by the Indian Tribe or Tribal Organization.

''(f) LIMITATION.—Absent specific written authorization by the governing body of an Indian Tribe for the period of such authorization (which may not be for a period of more than 1 year and which may be revoked at any time upon written notice by the governing body to the Service), the United States shall not have a right of recovery under this section if the injury, illness, or disability for which health services were provided is covered under a self-insurance plan funded by an Indian Tribe, Tribal Organization, or urban Indian organization. Where such authorization is provided, the Service may receive and expend such amounts for the provision of additional health services consistent with such authorization.

''(g) COSTS AND ATTORNEYS' FEES.—In any action brought to enforce the provisions of this section, a prevailing plaintiff shall be awarded its reasonable attorneys' fees and costs of litigation.

''(h) NONAPPLICATION OF CLAIMS FILING REQUIREMENTS.—An insurance company, health maintenance organization, self-insurance plan, managed care plan, or other health care plan or program (under the Social Security Act or otherwise) may not deny a claim for benefits submitted by the Service or by an Indian Tribe or Tribal

Organization based on the format in which the claim is submitted if such format complies with the format required for submission of claims under title XVIII of the Social Security Act or recognized under section 1175 of such Act.

''(i) APPLICATION TO URBAN INDIAN ORGANIZATIONS.—The previous provisions of this section shall apply to urban Indian organizations with respect to populations served by such Organizations in the same manner they apply to Indian Tribes and Tribal Organizations with respect to populations served by such Indian Tribes and Tribal Organizations.

''(j) STATUTE OF LIMITATIONS.—The provisions of section 2415 of title 28, United States Code, shall apply to all actions commenced under this section, and the references therein to the United States are deemed to include Indian Tribes, Tribal Organizations, and urban Indian organizations.

''(k) SAVINGS.—Nothing in this section shall be construed to limit any right of recovery available to the United States, an Indian Tribe, or Tribal Organization under the provisions of any applicable, Federal, State, or Tribal law, including medical lien laws.

"SEC. 404. CREDITING OF REIMBURSEMENTS.

"(a) RETENTION OF AMOUNTS FOR USE BY PROGRAM.—Except as provided in section 202(f) (relating to the Catastrophic Health Emergency Fund) and section 806 (relating to health services for ineligible persons), all reimbursements received or recovered, including under section 806, by reason of the provision of health services by the Service, by an Indian Tribe or Tribal Organization, or by an urban Indian organization, shall be credited to the Service, such Indian Tribe or Tribal Organization, or such urban Indian organization, respectively, and may be used as provided in section 401. In the case of such a service provided by or through a Service Unit, such amounts shall be credited to such unit and used for such purposes.

"(b) NO OFFSET OF AMOUNTS.—The Service may not offset or limit any amount obligated to any Service Unit or entity receiving funding from the Service because of the receipt of reimbursements under subsection (a).

"SEC. 405. PURCHASING HEALTH CARE COVERAGE.

"(a) PURCHASING COVERAGE.—

"(1) IN GENERAL.—Insofar as amounts are made available under law (including a provision of the Social Security Act, the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.), or other law, other than under section 402)

to Indian Tribes, Tribal Organizations, and urban Indian organizations for health benefits for Service beneficiaries, Indian Tribes, Tribal Organizations, and urban Indian organizations may use such amounts to purchase health benefits coverage that qualifies as creditable coverage under section 2701(c)(1) of the Public Health Service Act for such beneficiaries, including, subject to paragraph (2), through—

''(A) a tribally owned and operated health care plan;

''(B) a State or locally authorized or licensed health care plan;

''(C) a health insurance provider or managed care organization; or

''(D) a self-insured plan.

''(2) EXCEPTION.—The coverage provided under paragraph (1) may not include coverage consisting of—

''(A) benefits provided under a health flexible spending arrangement (as defined in section 106(c)(2) of the Internal Revenue Code of 1986); or

''(B) a high deductible health plan (as defined in section 223(c)(2) of such Code), with-

out regard to whether the plan is purchased in conjunction with a health savings account (as defined under section 223(d) of such Code).

''(3) PERMITTING PURCHASE OF COVERAGE BASED ON FINANCIAL NEED.—The purchase of coverage by an Indian Tribe, Tribal Organization, or urban Indian organization under this subsection may be based on the financial needs of beneficiaries (as determined by the Indian Tribe or Tribes being served based on a schedule of income levels developed or implemented by such Indian Tribe or Tribes).

''(b) EXPENSES FOR SELF-INSURED PLAN.—In the case of a self-insured plan under subsection (a)(4), the amounts may be used for expenses of operating the plan, including administration and insurance to limit the financial risks to the entity offering the plan.

''(c) CONSTRUCTION.—Nothing in this section shall be construed as affecting the use of any amounts not referred to in subsection (a).

''SEC. 406. SHARING ARRANGEMENTS WITH FEDERAL AGENCIES.

''(a) AUTHORITY.—

''(1) IN GENERAL.—The Secretary may enter into (or expand) arrangements for the sharing of

medical facilities and services between the Service, Indian Tribes, and Tribal Organizations and the Department of Veterans Affairs and the Department of Defense.

''(2) CONSULTATION BY SECRETARY REQUIRED.—The Secretary may not finalize any arrangement between the Service and a Department described in paragraph (1) without first consulting with the Indian Tribes which will be significantly affected by the arrangement.

''(b) LIMITATIONS.—The Secretary shall not take any action under this section or under subchapter IV of chapter 81 of title 38, United States Code, which would impair—

''(1) the priority access of any Indian to health care services provided through the Service and the eligibility of any Indian to receive health services through the Service;

''(2) the quality of health care services provided to any Indian through the Service;

''(3) the priority access of any veteran to health care services provided by the Department of Veterans Affairs;

''(4) the quality of health care services provided by the Department of Veterans Affairs or the Department of Defense; or

''(5) the eligibility of any Indian who is a veteran to receive health services through the Department of Veterans Affairs.

''(c) REIMBURSEMENT.—The Service, Indian Tribe, or Tribal Organization shall be reimbursed by the Department of Veterans Affairs or the Department of Defense (as the case may be) where services are provided through the Service, an Indian Tribe, or a Tribal Organization to beneficiaries eligible for services from either such Department, notwithstanding any other provision of law.

''(d) CONSTRUCTION.—Nothing in this section may be construed as creating any right of a non-Indian veteran to obtain health services from the Service.

''SEC. 407. ELIGIBLE INDIAN VETERAN SERVICES.

''(a) FINDINGS; PURPOSE.—

''(1) FINDINGS.—Congress finds that—

''(A) collaborations between the Secretary and the Secretary of Veterans Affairs regarding the treatment of Indian veterans at facilities of the Service should be encouraged to the maximum extent practicable; and

''(B) increased enrollment for services of the Department of Veterans Affairs by veterans who are members of Indian tribes should be encouraged to the maximum extent practicable.

''(2) PURPOSE.—The purpose of this section is to reaffirm the goals stated in the document entitled 'Memorandum of Understanding Between the VA/Veterans Health Administration And HHS/Indian Health Service' and dated February 25, 2003 (relating to cooperation and resource sharing between the Veterans Health Administration and Service).

''(b) DEFINITIONS.—In this section:

''(1) ELIGIBLE INDIAN VETERAN.—The term 'eligible Indian veteran' means an Indian or Alaska Native veteran who receives any medical service that is—

''(A) authorized under the laws administered by the Secretary of Veterans Affairs; and

''(B) administered at a facility of the Service (including a facility operated by an Indian tribe or tribal organization through a contract or compact with the Service under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.)) pursuant to a local memorandum of understanding.

''(2) LOCAL MEMORANDUM OF UNDERSTANDING.—The term 'local memorandum of understanding' means a memorandum of understanding between the Secretary (or a designee, including the director of any Area Office of the Service) and the Secretary of Veterans Affairs (or a designee) to implement the document entitled 'Memorandum of Understanding Between the VA/Veterans Health Administration And HHS/Indian Health Service' and dated February 25, 2003 (relating to cooperation and resource sharing between the Veterans Health Administration and Indian Health Service).

''(c) ELIGIBLE INDIAN VETERANS' EXPENSES.—

''(1) IN GENERAL.—Notwithstanding any other provision of law, the Secretary shall provide for veteran-related expenses incurred by eligible Indian veterans as described in subsection (b)(1)(B).

''(2) METHOD OF PAYMENT.—The Secretary shall establish such guidelines as the Secretary determines to be appropriate regarding the method of payments to the Secretary of Veterans Affairs under paragraph (1).

''(d) TRIBAL APPROVAL OF MEMORANDA.—In negotiating a local memorandum of understanding with the Secretary of Veterans Affairs regarding the provision of

services to eligible Indian veterans, the Secretary shall consult with each Indian tribe that would be affected by the local memorandum of understanding.

''(e) FUNDING.—

''(1) TREATMENT.—Expenses incurred by the Secretary in carrying out subsection (c)(1) shall not be considered to be Contract Health Service expenses.

''(2) USE OF FUNDS.—Of funds made available to the Secretary in appropriations Acts for the Service (excluding funds made available for facilities, Contract Health Services, or contract support costs), the Secretary shall use such sums as are necessary to carry out this section.

''SEC. 408. PAYOR OF LAST RESORT.

''Indian Health Programs and health care programs operated by Urban Indian Organizations shall be the payor of last resort for services provided to persons eligible for services from Indian Health Programs and Urban Indian Organizations, notwithstanding any Federal, State, or local law to the contrary.

''SEC. 409. CONSULTATION.

''For provisions related to consultation with representatives of Indian Health Programs and urban Indian organizations with respect to the health care programs es-

tablished under titles XVIII, XIX, and XXI of the Social Security Act, see section 1139(d) of the Social Security Act (42 U.S.C. 1320b–9(d)).

"SEC. 410. STATE CHILDREN'S HEALTH INSURANCE PROGRAM (SCHIP).

''For provisions relating to—

''(1) outreach to families of Indian children likely to be eligible for child health assistance under the State children's health insurance program established under title XXI of the Social Security Act, see sections 2105(c)(2)(C) and 1139(a) of such Act (42 U.S.C. 1397ee(c)(2), 1320b–9); and

''(2) ensuring that child health assistance is provided under such program to targeted low-income children who are Indians and that payments are made under such program to Indian Health Programs and urban Indian organizations operating in the State that provide such assistance, see sections 2102(b)(3)(D) and 2105(c)(6)(B) of such Act (42 U.S.C. 1397bb(b)(3)(D), 1397ee(c)(6)(B)).

"SEC. 411. PREMIUM AND COST SHARING PROTECTIONS AND ELIGIBILITY DETERMINATIONS UNDER MEDICAID AND SCHIP AND PROTECTION OF CERTAIN INDIAN PROPERTY FROM MEDICAID ESTATE RECOVERY.

''For provisions relating to—

''(1) premiums or cost sharing protections for Indians furnished items or services directly by Indian Health Programs or through referral under the contract health service under the Medicaid program established under title XIX of the Social Security Act, see sections 1916(j) and 1916A(a)(1) of the Social Security Act (42 U.S.C. 1396o(j), 1396o–1(a)(1));

''(2) rules regarding the treatment of certain property for purposes of determining eligibility under such programs, see sections 1902(e)(13) and 2107(e)(1)(B) of such Act (42 U.S.C. 1396a(e)(13), 1397gg(e)(1)(B)); and

''(3) the protection of certain property from estate recovery provisions under the Medicaid program, see section 1917(b)(3)(B) of such Act (42 U.S.C. 1396p(b)(3)(B)).

"SEC. 412. TREATMENT UNDER MEDICAID AND SCHIP MANAGED CARE.

"For provisions relating to the treatment of Indians enrolled in a managed care entity under the Medicaid program under title XIX of the Social Security Act and Indian Health Programs and urban Indian organizations that are providers of items or services to such Indian enrollees, see sections 1932(h) and 2107(e)(1)(H) of the Social Security Act (42 U.S.C. 1396u–2(h), 1397gg(e)(1)(H)).

"SEC. 413. NAVAJO NATION MEDICAID AGENCY FEASIBILITY STUDY.

"(a) STUDY.—The Secretary shall conduct a study to determine the feasibility of treating the Navajo Nation as a State for the purposes of title XIX of the Social Security Act, to provide services to Indians living within the boundaries of the Navajo Nation through an entity established having the same authority and performing the same functions as single-State Medicaid agencies responsible for the administration of the State plan under title XIX of the Social Security Act.

"(b) CONSIDERATIONS.—In conducting the study, the Secretary shall consider the feasibility of—

"(1) assigning and paying all expenditures for the provision of services and related administration funds, under title XIX of the Social Security Act, to

Indians living within the boundaries of the Navajo Nation that are currently paid to or would otherwise be paid to the State of Arizona, New Mexico, or Utah;

''(2) providing assistance to the Navajo Nation in the development and implementation of such entity for the administration, eligibility, payment, and delivery of medical assistance under title XIX of the Social Security Act;

''(3) providing an appropriate level of matching funds for Federal medical assistance with respect to amounts such entity expends for medical assistance for services and related administrative costs; and

''(4) authorizing the Secretary, at the option of the Navajo Nation, to treat the Navajo Nation as a State for the purposes of title XIX of the Social Security Act (relating to the State children's health insurance program) under terms equivalent to those described in paragraphs (2) through (4).

''(c) REPORT.—Not later than 3 years after the date of enactment of the Indian Health Care Improvement Act Amendments of 2009, the Secretary shall submit to the Committee on Indian Affairs and Committee on Finance of the Senate and the Committee on Natural Resources

and Committee on Energy and Commerce of the House of Representatives a report that includes—

''(1) the results of the study under this section;

''(2) a summary of any consultation that occurred between the Secretary and the Navajo Nation, other Indian Tribes, the States of Arizona, New Mexico, and Utah, counties which include Navajo Lands, and other interested parties, in conducting this study;

''(3) projected costs or savings associated with establishment of such entity, and any estimated impact on services provided as described in this section in relation to probable costs or savings; and

''(4) legislative actions that would be required to authorize the establishment of such entity if such entity is determined by the Secretary to be feasible.

''SEC. 414. EXCEPTION FOR EXCEPTED BENEFITS.

''The previous provisions of this title shall not apply to the provision of excepted benefits described in paragraph (1)(A) or (3) of section 2791(c) of the Public Health Service Act (42 U.S.C. 300gg–91(c)).

''SEC. 415. AUTHORIZATION OF APPROPRIATIONS.

''There are authorized to be appropriated such sums as may be necessary to carry out this title.

"TITLE V—HEALTH SERVICES FOR URBAN INDIANS

"SEC. 501. PURPOSE.

''The purpose of this title is to establish and maintain programs in Urban Centers to make health services more accessible and available to Urban Indians.

"SEC. 502. CONTRACTS WITH, AND GRANTS TO, URBAN INDIAN ORGANIZATIONS.

''Under authority of the Act of November 2, 1921 (25 U.S.C. 13) (commonly known as the 'Snyder Act'), the Secretary, acting through the Service, shall enter into contracts with, or make grants to, urban Indian organizations to assist such organizations in the establishment and administration, within Urban Centers, of programs which meet the requirements set forth in this title. Subject to section 506, the Secretary, acting through the Service, shall include such conditions as the Secretary considers necessary to effect the purpose of this title in any contract into which the Secretary enters with, or in any grant the Secretary makes to, any urban Indian organization pursuant to this title.

"SEC. 503. CONTRACTS AND GRANTS FOR THE PROVISION OF HEALTH CARE AND REFERRAL SERVICES.

''(a) REQUIREMENTS FOR GRANTS AND CONTRACTS.—Under authority of the Act of November 2,

1921 (25 U.S.C. 13) (commonly known as the 'Snyder Act'), the Secretary, acting through the Service, shall enter into contracts with, and make grants to, urban Indian organizations for the provision of health care and referral services for Urban Indians. Any such contract or grant shall include requirements that the urban Indian organization successfully undertake to—

''(1) estimate the population of Urban Indians residing in the Urban Center or centers that the organization proposes to serve who are or could be recipients of health care or referral services;

''(2) estimate the current health status of Urban Indians residing in such Urban Center or centers;

''(3) estimate the current health care needs of Urban Indians residing in such Urban Center or centers;

''(4) provide basic health education, including health promotion and disease prevention education, to Urban Indians;

''(5) make recommendations to the Secretary and Federal, State, local, and other resource agencies on methods of improving health service programs to meet the needs of Urban Indians; and

''(6) where necessary, provide, or enter into contracts for the provision of, health care services for Urban Indians.

''(b) CRITERIA.—The Secretary, acting through the Service, shall, by regulation, prescribe the criteria for selecting urban Indian organizations to enter into contracts or receive grants under this section. Such criteria shall, among other factors, include—

''(1) the extent of unmet health care needs of Urban Indians in the Urban Center or centers involved;

''(2) the size of the urban Indian population in the Urban Center or centers involved;

''(3) the extent, if any, to which the activities set forth in subsection (a) would duplicate any project funded under this title, or under any current public health service project funded in a manner other than pursuant to this title;

''(4) the capability of an urban Indian organization to perform the activities set forth in subsection (a) and to enter into a contract with the Secretary or to meet the requirements for receiving a grant under this section;

''(5) the satisfactory performance and successful completion by an urban Indian organization of other contracts with the Secretary under this title;

''(6) the appropriateness and likely effectiveness of conducting the activities set forth in subsection (a) in an Urban Center or centers; and

''(7) the extent of existing or likely future participation in the activities set forth in subsection (a) by appropriate health and health-related Federal, State, local, and other agencies.

''(c) ACCESS TO HEALTH PROMOTION AND DISEASE PREVENTION PROGRAMS.—The Secretary, acting through the Service, shall facilitate access to or provide health promotion and disease prevention services for Urban Indians through grants made to urban Indian organizations administering contracts entered into or receiving grants under subsection (a).

''(d) IMMUNIZATION SERVICES.—

''(1) ACCESS OR SERVICES PROVIDED.—The Secretary, acting through the Service, shall facilitate access to, or provide, immunization services for Urban Indians through grants made to urban Indian organizations administering contracts entered into or receiving grants under this section.

''(2) DEFINITION.—For purposes of this subsection, the term 'immunization services' means services to provide without charge immunizations against vaccine-preventable diseases.

''(e) BEHAVIORAL HEALTH SERVICES.—

''(1) ACCESS OR SERVICES PROVIDED.—The Secretary, acting through the Service, shall facilitate access to, or provide, behavioral health services for Urban Indians through grants made to urban Indian organizations administering contracts entered into or receiving grants under subsection (a).

''(2) ASSESSMENT REQUIRED.—Except as provided by paragraph (3)(A), a grant may not be made under this subsection to an urban Indian organization until that organization has prepared, and the Service has approved, an assessment of the following:

''(A) The behavioral health needs of the urban Indian population concerned.

''(B) The behavioral health services and other related resources available to that population.

''(C) The barriers to obtaining those services and resources.

''(D) The needs that are unmet by such services and resources.

''(3) PURPOSES OF GRANTS.—Grants may be made under this subsection for the following:

''(A) To prepare assessments required under paragraph (2).

''(B) To provide outreach, educational, and referral services to Urban Indians regarding the availability of direct behavioral health services, to educate Urban Indians about behavioral health issues and services, and effect coordination with existing behavioral health providers in order to improve services to Urban Indians.

''(C) To provide outpatient behavioral health services to Urban Indians, including the identification and assessment of illness, therapeutic treatments, case management, support groups, family treatment, and other treatment.

''(D) To develop innovative behavioral health service delivery models which incorporate Indian cultural support systems and resources.

''(f) PREVENTION OF CHILD ABUSE.—

''(1) ACCESS OR SERVICES PROVIDED.—The Secretary, acting through the Service, shall facilitate access to or provide services for Urban Indians

through grants to urban Indian organizations administering contracts entered into or receiving grants under subsection (a) to prevent and treat child abuse (including sexual abuse) among Urban Indians.

''(2) EVALUATION REQUIRED.—Except as provided by paragraph (3)(A), a grant may not be made under this subsection to an urban Indian organization until that organization has prepared, and the Service has approved, an assessment that documents the prevalence of child abuse in the urban Indian population concerned and specifies the services and programs (which may not duplicate existing services and programs) for which the grant is requested.

''(3) PURPOSES OF GRANTS.—Grants may be made under this subsection for the following:

''(A) To prepare assessments required under paragraph (2).

''(B) For the development of prevention, training, and education programs for Urban Indians, including child education, parent education, provider training on identification and intervention, education on reporting requirements, prevention campaigns, and establishing

service networks of all those involved in Indian child protection.

''(C) To provide direct outpatient treatment services (including individual treatment, family treatment, group therapy, and support groups) to Urban Indians who are child victims of abuse (including sexual abuse) or adult survivors of child sexual abuse, to the families of such child victims, and to urban Indian perpetrators of child abuse (including sexual abuse).

''(4) CONSIDERATIONS WHEN MAKING GRANTS.—In making grants to carry out this subsection, the Secretary shall take into consideration—

''(A) the support for the urban Indian organization demonstrated by the child protection authorities in the area, including committees or other services funded under the Indian Child Welfare Act of 1978 (25 U.S.C. 1901 et seq.), if any;

''(B) the capability and expertise demonstrated by the urban Indian organization to address the complex problem of child sexual abuse in the community; and

''(C) the assessment required under paragraph (2).

''(g) OTHER GRANTS.—The Secretary, acting through the Service, may enter into a contract with or make grants to an urban Indian organization that provides or arranges for the provision of health care services (through satellite facilities, provider networks, or otherwise) to Urban Indians in more than 1 Urban Center.

"SEC. 504. USE OF FEDERAL GOVERNMENT FACILITIES AND SOURCES OF SUPPLY.

''(a) IN GENERAL.—The Secretary may permit an urban Indian organization that has entered into a contract or received a grant pursuant to this title, in carrying out such contract or grant, to use existing facilities and all equipment therein or pertaining thereto and other personal property owned by the Federal Government within the Secretary's jurisdiction under such terms and conditions as may be agreed upon for their use and maintenance.

''(b) DONATIONS.—Subject to subsection (d), the Secretary may donate to an urban Indian organization that has entered into a contract or received a grant pursuant to this title any personal or real property determined to be excess to the needs of the Indian Health Service or

the General Services Administration for the purposes of carrying out the contract or grant.

''(c) ACQUISITION OF PROPERTY.—The Secretary may acquire excess or surplus government personal or real property for donation, subject to subsection (d) to an urban Indian organization that has entered into a contract or received a grant pursuant to this title if the Secretary determines that the property is appropriate for use by the urban Indian organization for a purpose for which a contract or grant is authorized under this title.

''(d) PRIORITY.—In the event that the Secretary receives a request for a specific item of personal or real property described in subsections (b) or (c) from an urban Indian organization and from an Indian Tribe or Tribal Organization, the Secretary shall give priority to the request for donation to the Indian Tribe or Tribal Organization if the Secretary receives the request from the Indian Tribe or Tribal Organization before the date the Secretary transfers title to the property or, if earlier, the date the Secretary transfers the property physically, to the urban Indian organization.

''(e) EXECUTIVE AGENCY STATUS.—For purposes of section 201(a) of the Federal Property and Administrative Services Act of 1949 (40 U.S.C. 481(a)) (relating to Federal sources of supply), an urban Indian organization that

has entered into a contract or received a grant pursuant to this title may be deemed to be an executive agency when carrying out such contract or grant.

"SEC. 505. CONTRACTS AND GRANTS FOR THE DETERMINATION OF UNMET HEALTH CARE NEEDS.

''(a) GRANTS AND CONTRACTS AUTHORIZED.—Under authority of the Act of November 2, 1921 (25 U.S.C. 13) (commonly known as the 'Snyder Act'), the Secretary, acting through the Service, may enter into contracts with or make grants to urban Indian organizations situated in Urban Centers for which contracts have not been entered into or grants have not been made under section 503.

''(b) PURPOSE.—The purpose of a contract or grant made under this section shall be the determination of the matters described in subsection (c)(1) in order to assist the Secretary in assessing the health status and health care needs of Urban Indians in the Urban Center involved and determining whether the Secretary should enter into a contract or make a grant under section 503 with respect to the urban Indian organization which the Secretary has entered into a contract with, or made a grant to, under this section.

''(c) GRANT AND CONTRACT REQUIREMENTS.—Any contract entered into, or grant made, by the Secretary under this section shall include requirements that—

''(1) the urban Indian organization successfully undertakes to—

''(A) document the health care status and unmet health care needs of urban Indians in the Urban Center involved; and

''(B) with respect to urban Indians in the Urban Center involved, determine the matters described in paragraphs (2), (3), (4), and (7) of section 503(b); and

''(2) the urban Indian organization complete performance of the contract, or carry out the requirements of the grant, within 1 year after the date on which the Secretary and such organization enter into such contract, or within 1 year after such organization receives such grant, whichever is applicable.

''(d) NO RENEWALS.—The Secretary may not renew any contract entered into or grant made under this section.

''SEC. 506. EVALUATIONS; RENEWALS.

''(a) PROCEDURES FOR EVALUATIONS.—The Secretary, acting through the Service, shall develop procedures to evaluate compliance with grant requirements and

compliance with and performance of contracts entered into by urban Indian organizations under this title. Such procedures shall include provisions for carrying out the requirements of this section.

''(b) EVALUATIONS.—The Secretary, acting through the Service, shall evaluate the compliance of each Urban Indian Organization which has entered into a contract or received a grant under section 503 with the terms of such contract or grant. For purposes of this evaluation, the Secretary shall—

''(1) acting through the Service, conduct an annual onsite evaluation of the organization; or

''(2) accept in lieu of such onsite evaluation evidence of the organization's provisional or full accreditation by a private independent entity recognized by the Secretary for purposes of conducting quality reviews of providers participating in the Medicare program under title XVIII of the Social Security Act.

''(c) NONCOMPLIANCE; UNSATISFACTORY PERFORMANCE.—If, as a result of the evaluations conducted under this section, the Secretary determines that an urban Indian organization has not complied with the requirements of a grant or complied with or satisfactorily performed a contract under section 503, the Secretary shall, prior to renewing such contract or grant, attempt to resolve with

the organization the areas of noncompliance or unsatisfactory performance and modify the contract or grant to prevent future occurrences of noncompliance or unsatisfactory performance. If the Secretary determines that the noncompliance or unsatisfactory performance cannot be resolved and prevented in the future, the Secretary shall not renew the contract or grant with the organization and is authorized to enter into a contract or make a grant under section 503 with another urban Indian organization which is situated in the same Urban Center as the urban Indian organization whose contract or grant is not renewed under this section.

''(d) CONSIDERATIONS FOR RENEWALS.—In determining whether to renew a contract or grant with an urban Indian organization under section 503 which has completed performance of a contract or grant under section 504, the Secretary shall review the records of the urban Indian organization, the reports submitted under section 507, and shall consider the results of the onsite evaluations or accreditations under subsection (b).

''SEC. 507. OTHER CONTRACT AND GRANT REQUIREMENTS.

''(a) PROCUREMENT.—Contracts with urban Indian organizations entered into pursuant to this title shall be in accordance with all Federal contracting laws and regulations relating to procurement except that in the discre-

tion of the Secretary, such contracts may be negotiated without advertising and need not conform to the provisions of sections 1304 and 3131 through 3133 of title 40, United States Code.

''(b) PAYMENTS UNDER CONTRACTS OR GRANTS.—

''(1) IN GENERAL.—Payments under any contracts or grants pursuant to this title, notwithstanding any term or condition of such contract or grant—

''(A) may be made in a single advance payment by the Secretary to the urban Indian organization by no later than the end of the first 30 days of the funding period with respect to which the payments apply, unless the Secretary determines through an evaluation under section 505 that the organization is not capable of administering such a single advance payment; and

''(B) if any portion thereof is unexpended by the urban Indian organization during the funding period with respect to which the payments initially apply, shall be carried forward for expenditure with respect to allowable or reimbursable costs incurred by the organization during 1 or more subsequent funding periods without additional justification or documenta-

tion by the organization as a condition of carrying forward the availability for expenditure of such funds.

''(2) SEMIANNUAL AND QUARTERLY PAYMENTS AND REIMBURSEMENTS.—If the Secretary determines under paragraph (1)(A) that an urban Indian organization is not capable of administering an entire single advance payment, on request of the urban Indian organization, the payments may be made—

''(A) in semiannual or quarterly payments by not later than 30 days after the date on which the funding period with respect to which the payments apply begins; or

''(B) by way of reimbursement.

''(c) REVISION OR AMENDMENT OF CONTRACTS.—Notwithstanding any provision of law to the contrary, the Secretary may, at the request and consent of an urban Indian organization, revise or amend any contract entered into by the Secretary with such organization under this title as necessary to carry out the purposes of this title.

''(d) FAIR AND UNIFORM SERVICES AND ASSISTANCE.—Contracts with or grants to urban Indian organizations and regulations adopted pursuant to this title shall include provisions to assure the fair and uniform provision

to urban Indians of services and assistance under such contracts or grants by such organizations.

"SEC. 508. REPORTS AND RECORDS.

''(a) REPORTS.—

''(1) IN GENERAL.—For each fiscal year during which an urban Indian organization receives or expends funds pursuant to a contract entered into or a grant received pursuant to this title, such urban Indian organization shall submit to the Secretary not more frequently than every 6 months, a report that includes the following:

''(A) In the case of a contract or grant under section 503, recommendations pursuant to section 503(a)(5).

''(B) Information on activities conducted by the organization pursuant to the contract or grant.

''(C) An accounting of the amounts and purpose for which Federal funds were expended.

''(D) A minimum set of data, using uniformly defined elements, as specified by the Secretary after consultation with urban Indian organizations.

''(2) HEALTH STATUS AND SERVICES.—

''(A) IN GENERAL.—Not later than 18 months after the date of enactment of the Indian Health Care Improvement Act Amendments of 2009, the Secretary, acting through the Service, shall submit to Congress a report evaluating—

''(i) the health status of urban Indians;

''(ii) the services provided to Indians pursuant to this title; and

''(iii) areas of unmet needs in the delivery of health services to urban Indians.

''(B) CONSULTATION AND CONTRACTS.—In preparing the report under paragraph (1), the Secretary—

''(i) shall consult with urban Indian organizations; and

''(ii) may enter into a contract with a national organization representing urban Indian organizations to conduct any aspect of the report.

''(b) AUDIT.—The reports and records of the urban Indian organization with respect to a contract or grant under this title shall be subject to audit by the Secretary and the Comptroller General of the United States.

''(c) COSTS OF AUDITS.—The Secretary shall allow as a cost of any contract or grant entered into or awarded under section 502 or 503 the cost of an annual independent financial audit conducted by—

''(1) a certified public accountant; or

''(2) a certified public accounting firm qualified to conduct Federal compliance audits.

''SEC. 509. LIMITATION ON CONTRACT AUTHORITY.

''The authority of the Secretary to enter into contracts or to award grants under this title shall be to the extent, and in an amount, provided for in appropriation Acts.

''SEC. 510. FACILITIES.

''(a) GRANTS.—The Secretary, acting through the Service, may make grants to contractors or grant recipients under this title for the lease, purchase, renovation, construction, or expansion of facilities, including leased facilities, in order to assist such contractors or grant recipients in complying with applicable licensure or certification requirements.

''(b) LOAN FUND STUDY.—The Secretary, acting through the Service, may carry out a study to determine the feasibility of establishing a loan fund to provide to urban Indian organizations direct loans or guarantees for loans for the construction of health care facilities in a

manner consistent with section 309, including by submitting a report in accordance with subsection (c) of that section.

"SEC. 511. DIVISION OF URBAN INDIAN HEALTH.

"There is established within the Service a Division of Urban Indian Health, which shall be responsible for—

"(1) carrying out the provisions of this title;

"(2) providing central oversight of the programs and services authorized under this title; and

"(3) providing technical assistance to urban Indian organizations.

"SEC. 512. GRANTS FOR ALCOHOL AND SUBSTANCE ABUSE-RELATED SERVICES.

"(a) GRANTS AUTHORIZED.—The Secretary, acting through the Service, may make grants for the provision of health-related services in prevention of, treatment of, rehabilitation of, or school- and community-based education regarding, alcohol and substance abuse in Urban Centers to those urban Indian organizations with which the Secretary has entered into a contract under this title or under section 201.

"(b) GOALS.—Each grant made pursuant to subsection (a) shall set forth the goals to be accomplished pursuant to the grant. The goals shall be specific to each grant as agreed to between the Secretary and the grantee.

''(c) CRITERIA.—The Secretary shall establish criteria for the grants made under subsection (a), including criteria relating to the following:

''(1) The size of the urban Indian population.

''(2) Capability of the organization to adequately perform the activities required under the grant.

''(3) Satisfactory performance standards for the organization in meeting the goals set forth in such grant. The standards shall be negotiated and agreed to between the Secretary and the grantee on a grant-by-grant basis.

''(4) Identification of the need for services.

''(d) ALLOCATION OF GRANTS.—The Secretary shall develop a methodology for allocating grants made pursuant to this section based on the criteria established pursuant to subsection (c).

''(e) GRANTS SUBJECT TO CRITERIA.—Any grant received by an urban Indian organization under this Act for substance abuse prevention, treatment, and rehabilitation shall be subject to the criteria set forth in subsection (c).

"SEC. 513. TREATMENT OF CERTAIN DEMONSTRATION PROJECTS.

''Notwithstanding any other provision of law, the Tulsa Clinic and Oklahoma City Clinic demonstration projects shall—

''(1) be permanent programs within the Service's direct care program;

''(2) continue to be treated as Service Units and Operating Units in the allocation of resources and coordination of care; and

''(3) continue to meet the requirements and definitions of an urban Indian organization in this Act, and shall not be subject to the provisions of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.).

"SEC. 514. URBAN NIAAA TRANSFERRED PROGRAMS.

''(a) GRANTS AND CONTRACTS.—The Secretary, through the Division of Urban Indian Health, shall make grants or enter into contracts with urban Indian organizations, to take effect not later than September 30, 2010, for the administration of urban Indian alcohol programs that were originally established under the National Institute on Alcoholism and Alcohol Abuse (hereafter in this section referred to as 'NIAAA') and transferred to the Service.

''(b) USE OF FUNDS.—Grants provided or contracts entered into under this section shall be used to provide support for the continuation of alcohol prevention and treatment services for urban Indian populations and such other objectives as are agreed upon between the Service and a recipient of a grant or contract under this section.

''(c) ELIGIBILITY.—Urban Indian organizations that operate Indian alcohol programs originally funded under the NIAAA and subsequently transferred to the Service are eligible for grants or contracts under this section.

''(d) REPORT.—The Secretary shall evaluate and report to Congress on the activities of programs funded under this section not less than every 5 years.

''SEC. 515. CONFERRING WITH URBAN INDIAN ORGANIZATIONS.

''(a) IN GENERAL.—The Secretary shall ensure that the Service confers or conferences, to the greatest extent practicable, with Urban Indian Organizations.

''(b) DEFINITION OF CONFER; CONFERENCE.—In this section, the terms 'confer' and 'conference' mean an open and free exchange of information and opinions that—

''(1) leads to mutual understanding and comprehension; and

''(2) emphasizes trust, respect, and shared responsibility.

"SEC. 516. URBAN YOUTH TREATMENT CENTER DEMONSTRATION.

''(a) CONSTRUCTION AND OPERATION.—

''(1) IN GENERAL.—The Secretary, acting through the Service, through grant or contract, shall fund the construction and operation of at least 1 residential treatment center in each Service Area that meets the eligibility requirements set forth in subsection (b) to demonstrate the provision of alcohol and substance abuse treatment services to Urban Indian youth in a culturally competent residential setting.

''(2) TREATMENT.—Each residential treatment center described in paragraph (1) shall be in addition to any facilities constructed under section 707(b).

''(b) ELIGIBILITY REQUIREMENTS.—To be eligible to obtain a facility under subsection (a)(1), a Service Area shall meet the following requirements:

''(1) There is an Urban Indian Organization in the Service Area.

''(2) There reside in the Service Area Urban Indian youth with need for alcohol and substance abuse treatment services in a residential setting.

''(3) There is a significant shortage of culturally competent residential treatment services for Urban Indian youth in the Service Area.

''SEC. 517. GRANTS FOR DIABETES PREVENTION, TREATMENT, AND CONTROL.

''(a) GRANTS AUTHORIZED.—The Secretary may make grants to those urban Indian organizations that have entered into a contract or have received a grant under this title for the provision of services for the prevention and treatment of, and control of the complications resulting from, diabetes among urban Indians.

''(b) GOALS.—Each grant made pursuant to subsection (a) shall set forth the goals to be accomplished under the grant. The goals shall be specific to each grant as agreed to between the Secretary and the grantee.

''(c) ESTABLISHMENT OF CRITERIA.—The Secretary shall establish criteria for the grants made under subsection (a) relating to—

''(1) the size and location of the urban Indian population to be served;

''(2) the need for prevention of and treatment of, and control of the complications resulting from,

diabetes among the urban Indian population to be served;

''(3) performance standards for the organization in meeting the goals set forth in such grant that are negotiated and agreed to by the Secretary and the grantee;

''(4) the capability of the organization to adequately perform the activities required under the grant; and

''(5) the willingness of the organization to collaborate with the registry, if any, established by the Secretary under section 203(e)(1)(B) in the Area Office of the Service in which the organization is located.

''(d) FUNDS SUBJECT TO CRITERIA.—Any funds received by an urban Indian organization under this Act for the prevention, treatment, and control of diabetes among urban Indians shall be subject to the criteria developed by the Secretary under subsection (c).

''SEC. 518. COMMUNITY HEALTH REPRESENTATIVES.

''The Secretary, acting through the Service, may enter into contracts with, and make grants to, urban Indian organizations for the employment of Indians trained as health service providers through the Community Health Representatives Program under section 109 in the provi-

sion of health care, health promotion, and disease prevention services to urban Indians.

''SEC. 519. EFFECTIVE DATE.

''The amendments made by the Indian Health Care Improvement Act Amendments of 2009 to this title shall take effect beginning on the date of enactment of that Act, regardless of whether the Secretary has promulgated regulations implementing such amendments.

''SEC. 520. ELIGIBILITY FOR SERVICES.

''Urban Indians shall be eligible for, and the ultimate beneficiaries of, health care or referral services provided pursuant to this title.

''SEC. 521. AUTHORIZATION OF APPROPRIATIONS.

''(a) IN GENERAL.—There are authorized to be appropriated such sums as may be necessary to carry out this title.

''(b) URBAN INDIAN ORGANIZATIONS.—The Secretary, acting through the Service, is authorized to establish programs, including programs for the awarding of grants, for urban Indian organizations that are identical to any programs established pursuant to section 126 (behavioral health training), section 209 (school health education), section 211 (prevention of communicable diseases), section 701 (behavioral health prevention and

treatment services), and section 707(g) (multidrug abuse program).

"SEC. 522. HEALTH INFORMATION TECHNOLOGY.

''The Secretary, acting through the Service, may make grants to urban Indian organizations under this title for the development, adoption, and implementation of health information technology (as defined in section 3000(5) of the American Recovery and Reinvestment Act), telemedicine services development, and related infrastructure.

"TITLE VI—ORGANIZATIONAL IMPROVEMENTS

"SEC. 601. ESTABLISHMENT OF THE INDIAN HEALTH SERVICE AS AN AGENCY OF THE PUBLIC HEALTH SERVICE.

''(a) ESTABLISHMENT.—

''(1) IN GENERAL.—In order to more effectively and efficiently carry out the responsibilities, authorities, and functions of the United States to provide health care services to Indians and Indian Tribes, as are or may be hereafter provided by Federal statute or treaties, there is established within the Public Health Service of the Department the Indian Health Service.

''(2) ASSISTANT SECRETARY OF INDIAN HEALTH.—The Service shall be administered by an Assistant Secretary of Indian Health, who shall be appointed by the President, by and with the advice and consent of the Senate. The Assistant Secretary shall report to the Secretary. Effective with respect to an individual appointed by the President, by and with the advice and consent of the Senate, after January 1, 2010, the term of service of the Assistant Secretary shall be 4 years. An Assistant Secretary may serve more than 1 term.

''(3) INCUMBENT.—The individual serving in the position of Director of the Service on the day before the date of enactment of the Indian Health Care Improvement Act Amendments of 2009 shall serve as Assistant Secretary.

''(4) ADVOCACY AND CONSULTATION.—The position of Assistant Secretary is established to, in a manner consistent with the government-to-government relationship between the United States and Indian Tribes—

''(A) facilitate advocacy for the development of appropriate Indian health policy; and

''(B) promote consultation on matters relating to Indian health.

''(b) AGENCY.—The Service shall be an agency within the Public Health Service of the Department, and shall not be an office, component, or unit of any other agency of the Department.

''(c) DUTIES.—The Assistant Secretary shall—

''(1) perform all functions that were, on the day before the date of enactment of the Indian Health Care Improvement Act Amendments of 2009, carried out by or under the direction of the individual serving as Director of the Service on that day;

''(2) perform all functions of the Secretary relating to the maintenance and operation of hospital and health facilities for Indians and the planning for, and provision and utilization of, health services for Indians;

''(3) administer all health programs under which health care is provided to Indians based upon their status as Indians which are administered by the Secretary, including programs under—

''(A) this Act;

''(B) the Act of November 2, 1921 (25 U.S.C. 13);

''(C) the Act of August 5, 1954 (42 U.S.C. 2001 et seq.);

''(D) the Act of August 16, 1957 (42 U.S.C. 2005 et seq.); and

''(E) the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.);

''(4) administer all scholarship and loan functions carried out under title I;

''(5) report directly to the Secretary concerning all policy- and budget-related matters affecting Indian health;

''(6) collaborate with the Assistant Secretary for Health concerning appropriate matters of Indian health that affect the agencies of the Public Health Service;

''(7) advise each Assistant Secretary of the Department concerning matters of Indian health with respect to which that Assistant Secretary has authority and responsibility;

''(8) advise the heads of other agencies and programs of the Department concerning matters of Indian health with respect to which those heads have authority and responsibility;

''(9) coordinate the activities of the Department concerning matters of Indian health; and

''(10) perform such other functions as the Secretary may designate.

''(d) AUTHORITY.—

''(1) IN GENERAL.—The Secretary, acting through the Assistant Secretary, shall have the authority—

''(A) except to the extent provided for in paragraph (2), to appoint and compensate employees for the Service in accordance with title 5, United States Code;

''(B) to enter into contracts for the procurement of goods and services to carry out the functions of the Service; and

''(C) to manage, expend, and obligate all funds appropriated for the Service.

''(2) PERSONNEL ACTIONS.—Notwithstanding any other provision of law, the provisions of section 12 of the Act of June 18, 1934 (48 Stat. 986; 25 U.S.C. 472), shall apply to all personnel actions taken with respect to new positions created within the Service as a result of its establishment under subsection (a).

''(e) REFERENCES.—Any reference to the Director of the Indian Health Service in any other Federal law, Executive order, rule, regulation, or delegation of authority, or

in any document of or relating to the Director of the Indian Health Service, shall be deemed to refer to the Assistant Secretary.

"SEC. 602. AUTOMATED MANAGEMENT INFORMATION SYSTEM.

''(a) ESTABLISHMENT.—

''(1) IN GENERAL.—The Secretary shall establish an automated management information system for the Service.

''(2) REQUIREMENTS OF SYSTEM.—The information system established under paragraph (1) shall include—

''(A) a financial management system;

''(B) a patient care information system for each area served by the Service;

''(C) privacy protections consistent with the regulations promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996 or, to the extent consistent with such regulations, other Federal rules applicable to privacy of automated management information systems of a Federal agency;

''(D) a services-based cost accounting component that provides estimates of the costs as-

sociated with the provision of specific medical treatments or services in each Area office of the Service;

''(E) an interface mechanism for patient billing and accounts receivable system; and

''(F) a training component.

''(b) PROVISION OF SYSTEMS TO TRIBES AND ORGANIZATIONS.—The Secretary shall provide each Tribal Health Program automated management information systems which—

''(1) meet the management information needs of such Tribal Health Program with respect to the treatment by the Tribal Health Program of patients of the Service; and

''(2) meet the management information needs of the Service.

''(c) ACCESS TO RECORDS.—The Service shall provide access of patients to their medical or health records which are held by, or on behalf of, the Service in accordance with the regulations promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996 or, to the extent consistent with such regulations, other Federal rules applicable to access to health care records.

''(d) AUTHORITY TO ENHANCE INFORMATION TECHNOLOGY.—The Secretary, acting through the Assistant Secretary, shall have the authority to enter into contracts, agreements, or joint ventures with other Federal agencies, States, private and nonprofit organizations, for the purpose of enhancing information technology in Indian Health Programs and facilities.

''SEC. 603. AUTHORIZATION OF APPROPRIATIONS.

''There is authorized to be appropriated such sums as may be necessary to carry out this title.

''TITLE VII—BEHAVIORAL HEALTH PROGRAMS

''SEC. 701. BEHAVIORAL HEALTH PREVENTION AND TREATMENT SERVICES.

''(a) PURPOSES.—The purposes of this section are as follows:

''(1) To authorize and direct the Secretary, acting through the Service, to develop a comprehensive behavioral health prevention and treatment program which emphasizes collaboration among alcohol and substance abuse, social services, and mental health programs.

''(2) To provide information, direction, and guidance relating to mental illness and dysfunction and self-destructive behavior, including child abuse

and family violence, to those Federal, tribal, State, and local agencies responsible for programs in Indian communities in areas of health care, education, social services, child and family welfare, alcohol and substance abuse, law enforcement, and judicial services.

''(3) To assist Indian Tribes to identify services and resources available to address mental illness and dysfunctional and self-destructive behavior.

''(4) To provide authority and opportunities for Indian Tribes and Tribal Organizations to develop, implement, and coordinate with community-based programs which include identification, prevention, education, referral, and treatment services, including through multidisciplinary resource teams.

''(5) To ensure that Indians, as citizens of the United States and of the States in which they reside, have the same access to behavioral health services to which all citizens have access.

''(6) To modify or supplement existing programs and authorities in the areas identified in paragraph (2).

''(b) PLANS.—

''(1) DEVELOPMENT.—The Secretary, acting through the Service, shall encourage Indian Tribes

and Tribal Organizations to develop tribal plans, and urban Indian organizations to develop local plans, and for all such groups to participate in developing areawide plans for Indian Behavioral Health Services. The plans shall include, to the extent feasible, the following components:

''(A) An assessment of the scope of alcohol or other substance abuse, mental illness, and dysfunctional and self-destructive behavior, including suicide, child abuse, and family violence, among Indians, including—

''(i) the number of Indians served who are directly or indirectly affected by such illness or behavior; or

''(ii) an estimate of the financial and human cost attributable to such illness or behavior.

''(B) An assessment of the existing and additional resources necessary for the prevention and treatment of such illness and behavior, including an assessment of the progress toward achieving the availability of the full continuum of care described in subsection (c).

''(C) An estimate of the additional funding needed by the Service, Indian Tribes, Tribal

Organizations, and urban Indian organizations to meet their responsibilities under the plans.

''(2) NATIONAL CLEARINGHOUSE.—The Secretary, acting through the Service, shall coordinate with existing national clearinghouses and information centers to include at the clearinghouses and centers plans and reports on the outcomes of such plans developed by Indian Tribes, Tribal Organizations, urban Indian organizations, and Service Areas relating to behavioral health. The Secretary shall ensure access to these plans and outcomes by any Indian Tribe, Tribal Organization, urban Indian organization, or the Service.

''(3) TECHNICAL ASSISTANCE.—The Secretary shall provide technical assistance to Indian Tribes, Tribal Organizations, and urban Indian organizations in preparation of plans under this section and in developing standards of care that may be used and adopted locally.

''(c) PROGRAMS.—The Secretary, acting through the Service, shall provide, to the extent feasible and if funding is available, programs including the following:

''(1) COMPREHENSIVE CARE.—A comprehensive continuum of behavioral health care which provides—

''(A) community-based prevention, intervention, outpatient, and behavioral health aftercare;

''(B) detoxification (social and medical);

''(C) acute hospitalization;

''(D) intensive outpatient/day treatment;

''(E) residential treatment;

''(F) transitional living for those needing a temporary, stable living environment that is supportive of treatment and recovery goals;

''(G) emergency shelter;

''(H) intensive case management; and

''(I) diagnostic services.

''(2) CHILD CARE.—Behavioral health services for Indians from birth through age 17, including—

''(A) preschool and school age fetal alcohol disorder services, including assessment and behavioral intervention;

''(B) mental health and substance abuse services (emotional, organic, alcohol, drug, inhalant, and tobacco);

''(C) identification and treatment of co-occurring disorders and comorbidity;

''(D) prevention of alcohol, drug, inhalant, and tobacco use;

''(E) early intervention, treatment, and aftercare;

''(F) promotion of healthy approaches to risk and safety issues; and

''(G) identification and treatment of neglect and physical, mental, and sexual abuse.

''(3) ADULT CARE.—Behavioral health services for Indians from age 18 through 55, including—

''(A) early intervention, treatment, and aftercare;

''(B) mental health and substance abuse services (emotional, alcohol, drug, inhalant, and tobacco), including sex specific services;

''(C) identification and treatment of co-occurring disorders (dual diagnosis) and comorbidity;

''(D) promotion of healthy approaches for risk-related behavior;

''(E) treatment services for women at risk of giving birth to a child with a fetal alcohol disorder; and

''(F) sex specific treatment for sexual assault and domestic violence.

''(4) FAMILY CARE.—Behavioral health services for families, including—

''(A) early intervention, treatment, and aftercare for affected families;

''(B) treatment for sexual assault and domestic violence; and

''(C) promotion of healthy approaches relating to parenting, domestic violence, and other abuse issues.

''(5) ELDER CARE.—Behavioral health services for Indians 56 years of age and older, including—

''(A) early intervention, treatment, and aftercare;

''(B) mental health and substance abuse services (emotional, alcohol, drug, inhalant, and tobacco), including sex specific services;

''(C) identification and treatment of co-occurring disorders (dual diagnosis) and comorbidity;

''(D) promotion of healthy approaches to managing conditions related to aging;

''(E) sex specific treatment for sexual assault, domestic violence, neglect, physical and mental abuse and exploitation; and

''(F) identification and treatment of dementias regardless of cause.

''(d) COMMUNITY BEHAVIORAL HEALTH PLAN.—

''(1) ESTABLISHMENT.—The governing body of any Indian Tribe, Tribal Organization, or urban Indian organization may adopt a resolution for the establishment of a community behavioral health plan providing for the identification and coordination of available resources and programs to identify, prevent, or treat substance abuse, mental illness, or dysfunctional and self-destructive behavior, including child abuse and family violence, among its members or its service population. This plan should include behavioral health services, social services, intensive outpatient services, and continuing aftercare.

''(2) TECHNICAL ASSISTANCE.—At the request of an Indian Tribe, Tribal Organization, or urban Indian organization, the Bureau of Indian Affairs and the Service shall cooperate with and provide technical assistance to the Indian Tribe, Tribal Organization, or urban Indian organization in the development and implementation of such plan.

''(3) FUNDING.—The Secretary, acting through the Service, may make funding available to Indian Tribes and Tribal Organizations which adopt a resolution pursuant to paragraph (1) to obtain technical assistance for the development of a community be-

havioral health plan and to provide administrative support in the implementation of such plan.

''(e) COORDINATION FOR AVAILABILITY OF SERVICES.—The Secretary, acting through the Service, shall coordinate behavioral health planning, to the extent feasible, with other Federal agencies and with State agencies, to encourage comprehensive behavioral health services for Indians regardless of their place of residence.

''(f) MENTAL HEALTH CARE NEED ASSESSMENT.—Not later than 1 year after the date of enactment of the Indian Health Care Improvement Act Amendments of 2009, the Secretary, acting through the Service, shall make an assessment of the need for inpatient mental health care among Indians and the availability and cost of inpatient mental health facilities which can meet such need. In making such assessment, the Secretary shall consider the possible conversion of existing, underused Service hospital beds into psychiatric units to meet such need.

''SEC. 702. MEMORANDA OF AGREEMENT WITH THE DEPARTMENT OF THE INTERIOR.

''(a) CONTENTS.—Not later than 12 months after the date of enactment of the Indian Health Care Improvement Act Amendments of 2009, the Secretary, acting through the Service, and the Secretary of the Interior shall develop and enter into a memoranda of agreement, or review and

update any existing memoranda of agreement, as required by section 4205 of the Indian Alcohol and Substance Abuse Prevention and Treatment Act of 1986 (25 U.S.C. 2411) under which the Secretaries address the following:

''(1) The scope and nature of mental illness and dysfunctional and self-destructive behavior, including child abuse and family violence, among Indians.

''(2) The existing Federal, tribal, State, local, and private services, resources, and programs available to provide behavioral health services for Indians.

''(3) The unmet need for additional services, resources, and programs necessary to meet the needs identified pursuant to paragraph (1).

''(4)(A) The right of Indians, as citizens of the United States and of the States in which they reside, to have access to behavioral health services to which all citizens have access.

''(B) The right of Indians to participate in, and receive the benefit of, such services.

''(C) The actions necessary to protect the exercise of such right.

''(5) The responsibilities of the Bureau of Indian Affairs and the Service, including mental illness identification, prevention, education, referral, and

treatment services (including services through multidisciplinary resource teams), at the central, area, and agency and Service Unit, Service Area, and headquarters levels to address the problems identified in paragraph (1).

''(6) A strategy for the comprehensive coordination of the behavioral health services provided by the Bureau of Indian Affairs and the Service to meet the problems identified pursuant to paragraph (1), including—

''(A) the coordination of alcohol and substance abuse programs of the Service, the Bureau of Indian Affairs, and Indian Tribes and Tribal Organizations (developed under the Indian Alcohol and Substance Abuse Prevention and Treatment Act of 1986 (25 U.S.C. 2401 et seq.)) with behavioral health initiatives pursuant to this Act, particularly with respect to the referral and treatment of dually diagnosed individuals requiring behavioral health and substance abuse treatment; and

''(B) ensuring that the Bureau of Indian Affairs and Service programs and services (including multidisciplinary resource teams) addressing child abuse and family violence are co-

ordinated with such non-Federal programs and services.

''(7) Directing appropriate officials of the Bureau of Indian Affairs and the Service, particularly at the agency and Service Unit levels, to cooperate fully with tribal requests made pursuant to community behavioral health plans adopted under section 701(c) and section 4206 of the Indian Alcohol and Substance Abuse Prevention and Treatment Act of 1986 (25 U.S.C. 2412).

''(8) Providing for an annual review of such agreement by the Secretaries which shall be provided to Congress and Indian Tribes and Tribal Organizations.

''(b) SPECIFIC PROVISIONS REQUIRED.—The memoranda of agreement updated or entered into pursuant to subsection (a) shall include specific provisions pursuant to which the Service shall assume responsibility for—

''(1) the determination of the scope of the problem of alcohol and substance abuse among Indians, including the number of Indians within the jurisdiction of the Service who are directly or indirectly affected by alcohol and substance abuse and the financial and human cost;

''(2) an assessment of the existing and needed resources necessary for the prevention of alcohol and substance abuse and the treatment of Indians affected by alcohol and substance abuse; and

''(3) an estimate of the funding necessary to adequately support a program of prevention of alcohol and substance abuse and treatment of Indians affected by alcohol and substance abuse.

''(c) PUBLICATION.—Each memorandum of agreement entered into or renewed (and amendments or modifications thereto) under subsection (a) shall be published in the Federal Register. At the same time as publication in the Federal Register, the Secretary shall provide a copy of such memoranda, amendment, or modification to each Indian Tribe, Tribal Organization, and urban Indian organization.

''SEC. 703. COMPREHENSIVE BEHAVIORAL HEALTH PREVENTION AND TREATMENT PROGRAM.

''(a) ESTABLISHMENT.—

''(1) IN GENERAL.—The Secretary, acting through the Service, shall provide a program of comprehensive behavioral health, prevention, treatment, and aftercare, including Systems of Care, which shall include—

''(A) prevention, through educational intervention, in Indian communities;

''(B) acute detoxification, psychiatric hospitalization, residential, and intensive outpatient treatment;

''(C) community-based rehabilitation and aftercare;

''(D) community education and involvement, including extensive training of health care, educational, and community-based personnel;

''(E) specialized residential treatment programs for high-risk populations, including pregnant and postpartum women and their children; and

''(F) diagnostic services.

''(2) TARGET POPULATIONS.—The target population of such programs shall be members of Indian Tribes. Efforts to train and educate key members of the Indian community shall also target employees of health, education, judicial, law enforcement, legal, and social service programs.

''(b) CONTRACT HEALTH SERVICES.—

''(1) IN GENERAL.—The Secretary, acting through the Service, may enter into contracts with

public or private providers of behavioral health treatment services for the purpose of carrying out the program required under subsection (a).

''(2) PROVISION OF ASSISTANCE.—In carrying out this subsection, the Secretary shall provide assistance to Indian Tribes and Tribal Organizations to develop criteria for the certification of behavioral health service providers and accreditation of service facilities which meet minimum standards for such services and facilities.

''SEC. 704. MENTAL HEALTH TECHNICIAN PROGRAM.

''(a) IN GENERAL.—Under the authority of the Act of November 2, 1921 (25 U.S.C. 13) (commonly known as the 'Snyder Act'), the Secretary shall establish and maintain a mental health technician program within the Service which—

''(1) provides for the training of Indians as mental health technicians; and

''(2) employs such technicians in the provision of community-based mental health care that includes identification, prevention, education, referral, and treatment services.

''(b) PARAPROFESSIONAL TRAINING.—In carrying out subsection (a), the Secretary, acting through the Service, shall provide high-standard paraprofessional training

in mental health care necessary to provide quality care to the Indian communities to be served. Such training shall be based upon a curriculum developed or approved by the Secretary which combines education in the theory of mental health care with supervised practical experience in the provision of such care.

''(c) SUPERVISION AND EVALUATION OF TECHNICIANS.—The Secretary, acting through the Service, shall supervise and evaluate the mental health technicians in the training program.

''(d) TRADITIONAL HEALTH CARE PRACTICES.—The Secretary, acting through the Service, shall ensure that the program established pursuant to this subsection involves the use and promotion of the traditional health care practices of the Indian Tribes to be served.

''SEC. 705. LICENSING REQUIREMENT FOR MENTAL HEALTH CARE WORKERS.

''(a) IN GENERAL.—Subject to the provisions of section 221, and except as provided in subsection (b), any individual employed as a psychologist, social worker, or marriage and family therapist for the purpose of providing mental health care services to Indians in a clinical setting under this Act is required to be licensed as a psychologist, social worker, or marriage and family therapist, respectively.

''(b) TRAINEES.—An individual may be employed as a trainee in psychology, social work, or marriage and family therapy to provide mental health care services described in subsection (a) if such individual—

''(1) works under the direct supervision of a licensed psychologist, social worker, or marriage and family therapist, respectively;

''(2) is enrolled in or has completed at least 2 years of course work at a post-secondary, accredited education program for psychology, social work, marriage and family therapy, or counseling; and

''(3) meets such other training, supervision, and quality review requirements as the Secretary may establish.

''SEC. 706. INDIAN WOMEN TREATMENT PROGRAMS.

''(a) GRANTS.—The Secretary, consistent with section 701, may make grants to Indian Tribes, Tribal Organizations, and urban Indian organizations to develop and implement a comprehensive behavioral health program of prevention, intervention, treatment, and relapse prevention services that specifically addresses the cultural, historical, social, and child care needs of Indian women, regardless of age.

''(b) USE OF GRANT FUNDS.—A grant made pursuant to this section may be used to—

''(1) develop and provide community training, education, and prevention programs for Indian women relating to behavioral health issues, including fetal alcohol disorders;

''(2) identify and provide psychological services, counseling, advocacy, support, and relapse prevention to Indian women and their families; and

''(3) develop prevention and intervention models for Indian women which incorporate traditional health care practices, cultural values, and community and family involvement.

''(c) CRITERIA.—The Secretary, in consultation with Indian Tribes and Tribal Organizations, shall establish criteria for the review and approval of applications and proposals for funding under this section.

''(d) ALLOCATION OF FUNDS FOR URBAN INDIAN ORGANIZATIONS.—Twenty percent of the funds appropriated pursuant to this section shall be used to make grants to urban Indian organizations.

''SEC. 707. INDIAN YOUTH PROGRAM.

''(a) DETOXIFICATION AND REHABILITATION.—The Secretary, acting through the Service, consistent with section 701, shall develop and implement a program for acute detoxification and treatment for Indian youths, including behavioral health services. The program shall include re-

gional treatment centers designed to include detoxification and rehabilitation for both sexes on a referral basis and programs developed and implemented by Indian Tribes or Tribal Organizations at the local level under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.). Regional centers shall be integrated with the intake and rehabilitation programs based in the referring Indian community.

''(b) ALCOHOL AND SUBSTANCE ABUSE TREATMENT CENTERS OR FACILITIES.—

''(1) ESTABLISHMENT.—

''(A) IN GENERAL.—The Secretary, acting through the Service, shall construct, renovate, or, as necessary, purchase, and appropriately staff and operate, at least 1 youth regional treatment center or treatment network in each area under the jurisdiction of an Area Office.

''(B) AREA OFFICE IN CALIFORNIA.—For the purposes of this subsection, the Area Office in California shall be considered to be 2 Area Offices, 1 office whose jurisdiction shall be considered to encompass the northern area of the State of California, and 1 office whose jurisdiction shall be considered to encompass the remainder of the State of California for the pur-

pose of implementing California treatment networks.

''(2) FUNDING.—For the purpose of staffing and operating such centers or facilities, funding shall be pursuant to the Act of November 2, 1921 (25 U.S.C. 13).

''(3) LOCATION.—A youth treatment center constructed or purchased under this subsection shall be constructed or purchased at a location within the area described in paragraph (1) agreed upon (by appropriate tribal resolution) by a majority of the Indian Tribes to be served by such center.

''(4) SPECIFIC PROVISION OF FUNDS.—

''(A) IN GENERAL.—Notwithstanding any other provision of this title, the Secretary may, from amounts authorized to be appropriated for the purposes of carrying out this section, make funds available to—

''(i) the Tanana Chiefs Conference, Incorporated, for the purpose of leasing, constructing, renovating, operating, and maintaining a residential youth treatment facility in Fairbanks, Alaska; and

''(ii) the Southeast Alaska Regional Health Corporation to staff and operate a

residential youth treatment facility without regard to the proviso set forth in section 4(l) of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450b(l)).

''(B) PROVISION OF SERVICES TO ELIGIBLE YOUTHS.—Until additional residential youth treatment facilities are established in Alaska pursuant to this section, the facilities specified in subparagraph (A) shall make every effort to provide services to all eligible Indian youths residing in Alaska.

''(c) INTERMEDIATE ADOLESCENT BEHAVIORAL HEALTH SERVICES.—

''(1) IN GENERAL.—The Secretary, acting through the Service, may provide intermediate behavioral health services, which may incorporate Systems of Care, to Indian children and adolescents, including—

''(A) pretreatment assistance;

''(B) inpatient, outpatient, and aftercare services;

''(C) emergency care;

''(D) suicide prevention and crisis intervention; and

''(E) prevention and treatment of mental illness and dysfunctional and self-destructive behavior, including child abuse and family violence.

''(2) USE OF FUNDS.—Funds provided under this subsection may be used—

''(A) to construct or renovate an existing health facility to provide intermediate behavioral health services;

''(B) to hire behavioral health professionals;

''(C) to staff, operate, and maintain an intermediate mental health facility, group home, sober housing, transitional housing or similar facilities, or youth shelter where intermediate behavioral health services are being provided;

''(D) to make renovations and hire appropriate staff to convert existing hospital beds into adolescent psychiatric units; and

''(E) for intensive home- and community-based services.

''(3) CRITERIA.—The Secretary, acting through the Service, shall, in consultation with Indian Tribes and Tribal Organizations, establish criteria for the

review and approval of applications or proposals for funding made available pursuant to this subsection.

''(d) FEDERALLY OWNED STRUCTURES.—

''(1) IN GENERAL.—The Secretary, in consultation with Indian Tribes and Tribal Organizations, shall—

''(A) identify and use, where appropriate, federally owned structures suitable for local residential or regional behavioral health treatment for Indian youths; and

''(B) establish guidelines for determining the suitability of any such federally owned structure to be used for local residential or regional behavioral health treatment for Indian youths.

''(2) TERMS AND CONDITIONS FOR USE OF STRUCTURE.—Any structure described in paragraph (1) may be used under such terms and conditions as may be agreed upon by the Secretary and the agency having responsibility for the structure and any Indian Tribe or Tribal Organization operating the program.

''(e) REHABILITATION AND AFTERCARE SERVICES.—

''(1) IN GENERAL.—The Secretary, Indian Tribes, or Tribal Organizations, in cooperation with

the Secretary of the Interior, shall develop and implement within each Service Unit, community-based rehabilitation and follow-up services for Indian youths who are having significant behavioral health problems, and require long-term treatment, community reintegration, and monitoring to support the Indian youths after their return to their home community.

''(2) ADMINISTRATION.—Services under paragraph (1) shall be provided by trained staff within the community who can assist the Indian youths in their continuing development of self-image, positive problem-solving skills, and nonalcohol or substance abusing behaviors. Such staff may include alcohol and substance abuse counselors, mental health professionals, and other health professionals and paraprofessionals, including community health representatives.

''(f) INCLUSION OF FAMILY IN YOUTH TREATMENT PROGRAM.—In providing the treatment and other services to Indian youths authorized by this section, the Secretary, acting through the Service, shall provide for the inclusion of family members of such youths in the treatment programs or other services as may be appropriate. Not less than 10 percent of the funds appropriated for the pur-

poses of carrying out subsection (e) shall be used for outpatient care of adult family members related to the treatment of an Indian youth under that subsection.

''(g) MULTIDRUG ABUSE PROGRAM.—The Secretary, acting through the Service, shall provide, consistent with section 701, programs and services to prevent and treat the abuse of multiple forms of substances, including alcohol, drugs, inhalants, and tobacco, among Indian youths residing in Indian communities, on or near reservations, and in urban areas and provide appropriate mental health services to address the incidence of mental illness among such youths.

''(h) INDIAN YOUTH MENTAL HEALTH.—The Secretary, acting through the Service, shall collect data for the report under section 801 with respect to—

''(1) the number of Indian youth who are being provided mental health services through the Service and Tribal Health Programs;

''(2) a description of, and costs associated with, the mental health services provided for Indian youth through the Service and Tribal Health Programs;

''(3) the number of youth referred to the Service or Tribal Health Programs for mental health services;

''(4) the number of Indian youth provided residential treatment for mental health and behavioral problems through the Service and Tribal Health Programs, reported separately for on- and off-reservation facilities; and

''(5) the costs of the services described in paragraph (4).

"SEC. 708. INDIAN YOUTH TELEMENTAL HEALTH DEMONSTRATION PROJECT.

''(a) PURPOSE.—The purpose of this section is to authorize the Secretary to carry out a demonstration project to test the use of telemental health services in suicide prevention, intervention and treatment of Indian youth, including through—

''(1) the use of psychotherapy, psychiatric assessments, diagnostic interviews, therapies for mental health conditions predisposing to suicide, and alcohol and substance abuse treatment;

''(2) the provision of clinical expertise to, consultation services with, and medical advice and training for frontline health care providers working with Indian youth;

''(3) training and related support for community leaders, family members and health and education workers who work with Indian youth;

''(4) the development of culturally relevant educational materials on suicide; and

''(5) data collection and reporting.

''(b) DEFINITIONS.—For the purpose of this section, the following definitions shall apply:

''(1) DEMONSTRATION PROJECT.—The term 'demonstration project' means the Indian youth telemental health demonstration project authorized under subsection (c).

''(2) TELEMENTAL HEALTH.—The term 'telemental health' means the use of electronic information and telecommunications technologies to support long distance mental health care, patient and professional-related education, public health, and health administration.

''(c) AUTHORIZATION.—

''(1) IN GENERAL.—The Secretary is authorized to award grants under the demonstration project for the provision of telemental health services to Indian youth who—

''(A) have expressed suicidal ideas;

''(B) have attempted suicide; or

''(C) have mental health conditions that increase or could increase the risk of suicide.

''(2) ELIGIBILITY FOR GRANTS.—Such grants shall be awarded to Indian Tribes and Tribal Organizations that operate 1 or more facilities—

''(A) located in Alaska and part of the Alaska Federal Health Care Access Network;

''(B) reporting active clinical telehealth capabilities; or

''(C) offering school-based telemental health services relating to psychiatry to Indian youth.

''(3) GRANT PERIOD.—The Secretary shall award grants under this section for a period of up to 4 years.

''(4) AWARDING OF GRANTS.—Not more than 5 grants shall be provided under paragraph (1), with priority consideration given to Indian Tribes and Tribal Organizations that—

''(A) serve a particular community or geographic area where there is a demonstrated need to address Indian youth suicide;

''(B) enter in to collaborative partnerships with Indian Health Service or Tribal Health Programs or facilities to provide services under this demonstration project;

''(C) serve an isolated community or geographic area which has limited or no access to behavioral health services; or

''(D) operate a detention facility at which Indian youth are detained.

''(d) USE OF FUNDS.—

''(1) IN GENERAL.—An Indian Tribe or Tribal Organization shall use a grant received under subsection (c) for the following purposes:

''(A) To provide telemental health services to Indian youth, including the provision of—

''(i) psychotherapy;

''(ii) psychiatric assessments and diagnostic interviews, therapies for mental health conditions predisposing to suicide, and treatment; and

''(iii) alcohol and substance abuse treatment.

''(B) To provide clinician-interactive medical advice, guidance and training, assistance in diagnosis and interpretation, crisis counseling and intervention, and related assistance to Service, tribal, or urban clinicians and health services providers working with youth being served under this demonstration project.

''(C) To assist, educate and train community leaders, health education professionals and paraprofessionals, tribal outreach workers, and family members who work with the youth receiving telemental health services under this demonstration project, including with identification of suicidal tendencies, crisis intervention and suicide prevention, emergency skill development, and building and expanding networks among these individuals and with State and local health services providers.

''(D) To develop and distribute culturally appropriate community educational materials on—

''(i) suicide prevention;

''(ii) suicide education;

''(iii) suicide screening;

''(iv) suicide intervention; and

''(v) ways to mobilize communities with respect to the identification of risk factors for suicide.

''(E) For data collection and reporting related to Indian youth suicide prevention efforts.

''(2) TRADITIONAL HEALTH CARE PRACTICES.—In carrying out the purposes described in

paragraph (1), an Indian Tribe or Tribal Organization may use and promote the traditional health care practices of the Indian Tribes of the youth to be served.

''(e) APPLICATIONS.—To be eligible to receive a grant under subsection (c), an Indian Tribe or Tribal Organization shall prepare and submit to the Secretary an application, at such time, in such manner, and containing such information as the Secretary may require, including—

''(1) a description of the project that the Indian Tribe or Tribal Organization will carry out using the funds provided under the grant;

''(2) a description of the manner in which the project funded under the grant would—

''(A) meet the telemental health care needs of the Indian youth population to be served by the project; or

''(B) improve the access of the Indian youth population to be served to suicide prevention and treatment services;

''(3) evidence of support for the project from the local community to be served by the project;

''(4) a description of how the families and leadership of the communities or populations to be

served by the project would be involved in the development and ongoing operations of the project;

''(5) a plan to involve the tribal community of the youth who are provided services by the project in planning and evaluating the mental health care and suicide prevention efforts provided, in order to ensure the integration of community, clinical, environmental, and cultural components of the treatment; and

''(6) a plan for sustaining the project after Federal assistance for the demonstration project has terminated.

''(f) COLLABORATION; REPORTING TO NATIONAL CLEARINGHOUSE.—

''(1) COLLABORATION.—The Secretary, acting through the Service, shall encourage Indian Tribes and Tribal Organizations receiving grants under this section to collaborate to enable comparisons about best practices across projects.

''(2) REPORTING TO NATIONAL CLEARINGHOUSE.—The Secretary, acting through the Service, shall also encourage Indian Tribes and Tribal Organizations receiving grants under this section to submit relevant, declassified project information to the national clearinghouse authorized under section

701(b)(2) in order to better facilitate program performance and improve suicide prevention, intervention, and treatment services.

''(g) ANNUAL REPORT.—Each grant recipient shall submit to the Secretary an annual report that—

''(1) describes the number of telemental health services provided; and

''(2) includes any other information that the Secretary may require.

''(h) REPORT TO CONGRESS.—Not later than 270 days after the termination of the demonstration project, the Secretary shall submit to the Committee on Indian Affairs of the Senate and the Committee on Natural Resources and Committee on Energy and Commerce of the House of Representatives a final report, based on the annual reports provided by grant recipients under subsection (h), that—

''(1) describes the results of the projects funded by grants awarded under this section, including any data available which indicates the number of attempted suicides;

''(2) evaluates the impact of the telemental health services funded by the grants in reducing the number of completed suicides among Indian youth;

''(3) evaluates whether the demonstration project should be—

''(A) expanded to provide more than 5 grants; and

''(B) designated a permanent program; and

''(4) evaluates the benefits of expanding the demonstration project to include urban Indian organizations.

''(i) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated such sums as may be necessary to carry out this section.

''SEC. 709. INPATIENT AND COMMUNITY-BASED MENTAL HEALTH FACILITIES DESIGN, CONSTRUCTION, AND STAFFING.

''Not later than 1 year after the date of enactment of the Indian Health Care Improvement Act Amendments of 2009, the Secretary, acting through the Service, may provide, in each area of the Service, not less than 1 inpatient mental health care facility, or the equivalent, for Indians with behavioral health problems. For the purposes of this subsection, California shall be considered to be 2 Area Offices, 1 office whose location shall be considered to encompass the northern area of the State of California and 1 office whose jurisdiction shall be considered to en-

compass the remainder of the State of California. The Secretary shall consider the possible conversion of existing, underused Service hospital beds into psychiatric units to meet such need.

"SEC. 710. TRAINING AND COMMUNITY EDUCATION.

"(a) PROGRAM.—The Secretary, in cooperation with the Secretary of the Interior, shall develop and implement or assist Indian Tribes and Tribal Organizations to develop and implement, within each Service Unit or tribal program, a program of community education and involvement which shall be designed to provide concise and timely information to the community leadership of each tribal community. Such program shall include education about behavioral health issues to political leaders, Tribal judges, law enforcement personnel, members of tribal health and education boards, health care providers including traditional practitioners, and other critical members of each tribal community. Such program may also include community-based training to develop local capacity and tribal community provider training for prevention, intervention, treatment, and aftercare.

"(b) INSTRUCTION.—The Secretary, acting through the Service, shall provide instruction in the area of behavioral health issues, including instruction in crisis intervention and family relations in the context of alcohol and sub-

stance abuse, child sexual abuse, youth alcohol and substance abuse, and the causes and effects of fetal alcohol disorders to appropriate employees of the Bureau of Indian Affairs and the Service, and to personnel in schools or programs operated under any contract with the Bureau of Indian Affairs or the Service, including supervisors of emergency shelters and halfway houses described in section 4213 of the Indian Alcohol and Substance Abuse Prevention and Treatment Act of 1986 (25 U.S.C. 2433).

''(c) TRAINING MODELS.—In carrying out the education and training programs required by this section, the Secretary, in consultation with Indian Tribes, Tribal Organizations, Indian behavioral health experts, and Indian alcohol and substance abuse prevention experts, shall develop and provide community-based training models. Such models shall address—

''(1) the elevated risk of alcohol and behavioral health problems faced by children of alcoholics;

''(2) the cultural, spiritual, and multigenerational aspects of behavioral health problem prevention and recovery; and

''(3) community-based and multidisciplinary strategies, including Systems of Care, for preventing and treating behavioral health problems.

"SEC. 711. BEHAVIORAL HEALTH PROGRAM.

"(a) INNOVATIVE PROGRAMS.—The Secretary, acting through the Service, consistent with section 701, may plan, develop, implement, and carry out programs to deliver innovative community-based behavioral health services to Indians.

"(b) AWARDS; CRITERIA.—The Secretary may award a grant for a project under subsection (a) to an Indian Tribe or Tribal Organization and may consider the following criteria:

"(1) The project will address significant unmet behavioral health needs among Indians.

"(2) The project will serve a significant number of Indians.

"(3) The project has the potential to deliver services in an efficient and effective manner.

"(4) The Indian Tribe or Tribal Organization has the administrative and financial capability to administer the project.

"(5) The project may deliver services in a manner consistent with traditional health care practices.

"(6) The project is coordinated with, and avoids duplication of, existing services.

"(c) EQUITABLE TREATMENT.—For purposes of this subsection, the Secretary shall, in evaluating project applications or proposals, use the same criteria that the Sec-

retary uses in evaluating any other application or proposal for such funding.

"SEC. 712. FETAL ALCOHOL DISORDER PROGRAMS.

"(a) PROGRAMS.—

"(1) ESTABLISHMENT.—The Secretary, consistent with section 701 and acting through the Service, is authorized to establish and operate fetal alcohol disorder programs as provided in this section for the purposes of meeting the health status objectives specified in section 3.

"(2) USE OF FUNDS.—

"(A) IN GENERAL.—Funding provided pursuant to this section shall be used for the following:

"(i) To develop and provide for Indians community and in-school training, education, and prevention programs relating to fetal alcohol disorders.

"(ii) To identify and provide behavioral health treatment to high-risk Indian women and high-risk women pregnant with an Indian's child.

"(iii) To identify and provide appropriate psychological services, educational and vocational support, counseling, advo-

cacy, and information to fetal alcohol disorder affected Indians and their families or caretakers.

''(iv) To develop and implement counseling and support programs in schools for fetal alcohol disorder affected Indian children.

''(v) To develop prevention and intervention models which incorporate practitioners of traditional health care practices, cultural values, and community involvement.

''(vi) To develop, print, and disseminate education and prevention materials on fetal alcohol disorder.

''(vii) To develop and implement, in consultation with Indian Tribes, Tribal Organizations, and urban Indian organizations, culturally sensitive assessment and diagnostic tools including dysmorphology clinics and multidisciplinary fetal alcohol disorder clinics for use in Indian communities and Urban Centers.

''(B) ADDITIONAL USES.—In addition to any purpose under subparagraph (A), funding

provided pursuant to this section may be used for 1 or more of the following:

''(i) Early childhood intervention projects from birth on to mitigate the effects of fetal alcohol disorder among Indians.

''(ii) Community-based support services for Indians and women pregnant with Indian children.

''(iii) Community-based housing for adult Indians with fetal alcohol disorder.

''(3) CRITERIA FOR APPLICATIONS.—The Secretary shall establish criteria for the review and approval of applications for funding under this section.

''(b) SERVICES.—The Secretary, acting through the Service, shall—

''(1) develop and provide services for the prevention, intervention, treatment, and aftercare for those affected by fetal alcohol disorder in Indian communities; and

''(2) provide supportive services, including services to meet the special educational, vocational, school-to-work transition, and independent living needs of adolescent and adult Indians with fetal alcohol disorder.

''(c) TASK FORCE.—The Secretary shall establish a task force to be known as the Fetal Alcohol Disorder Task Force to advise the Secretary in carrying out subsection (b). Such task force shall be composed of representatives from the following:

''(1) The National Institute on Drug Abuse.

''(2) The National Institute on Alcohol and Alcoholism.

''(3) The Office of Substance Abuse Prevention.

''(4) The National Institute of Mental Health.

''(5) The Service.

''(6) The Office of Minority Health of the Department of Health and Human Services.

''(7) The Administration for Native Americans.

''(8) The National Institute of Child Health and Human Development (NICHD).

''(9) The Centers for Disease Control and Prevention.

''(10) The Bureau of Indian Affairs.

''(11) Indian Tribes.

''(12) Tribal Organizations.

''(13) urban Indian organizations.

''(14) Indian fetal alcohol spectrum disorders experts.

''(d) APPLIED RESEARCH PROJECTS.—The Secretary, acting through the Substance Abuse and Mental Health Services Administration, shall make grants to Indian Tribes, Tribal Organizations, and urban Indian organizations for applied research projects which propose to elevate the understanding of methods to prevent, intervene, treat, or provide rehabilitation and behavioral health aftercare for Indians and urban Indians affected by fetal alcohol spectrum disorders.

''(e) FUNDING FOR URBAN INDIAN ORGANIZATIONS.—Ten percent of the funds appropriated pursuant to this section shall be used to make grants to urban Indian organizations funded under title V.

"SEC. 713. CHILD SEXUAL ABUSE AND PREVENTION TREATMENT PROGRAMS.

''(a) ESTABLISHMENT.—The Secretary, acting through the Service, shall establish, consistent with section 701, in every Service Area, programs involving treatment for—

''(1) victims of sexual abuse who are Indian children or children in an Indian household; and

''(2) perpetrators of child sexual abuse who are Indian or members of an Indian household.

''(b) USE OF FUNDS.—Funding provided pursuant to this section shall be used for the following:

''(1) To develop and provide community education and prevention programs related to sexual abuse of Indian children or children in an Indian household.

''(2) To identify and provide behavioral health treatment to victims of sexual abuse who are Indian children or children in an Indian household, and to their family members who are affected by sexual abuse.

''(3) To develop prevention and intervention models which incorporate traditional health care practices, cultural values, and community involvement.

''(4) To develop and implement culturally sensitive assessment and diagnostic tools for use in Indian communities and Urban Centers.

''(5) To identify and provide behavioral health treatment to Indian perpetrators and perpetrators who are members of an Indian household—

''(A) making efforts to begin offender and behavioral health treatment while the perpetrator is incarcerated or at the earliest possible date if the perpetrator is not incarcerated; and

''(B) providing treatment after the perpetrator is released, until it is determined that the perpetrator is not a threat to children.

''(c) COORDINATION.—The programs established under subsection (a) shall be carried out in coordination with programs and services authorized under the Indian Child Protection and Family Violence Prevention Act (25 U.S.C. 3201 et seq.).

''SEC. 714. DOMESTIC AND SEXUAL VIOLENCE PREVENTION AND TREATMENT.

''(a) IN GENERAL.—The Secretary, in accordance with section 701, is authorized to establish in each Service Area programs involving the prevention and treatment of—

''(1) Indian victims of domestic violence or sexual abuse; and

''(2) perpetrators of domestic violence or sexual abuse who are Indian or members of an Indian household.

''(b) USE OF FUNDS.—Funds made available to carry out this section shall be used—

''(1) to develop and implement prevention programs and community education programs relating to domestic violence and sexual abuse;

''(2) to provide behavioral health services, including victim support services, and medical treatment (including examinations performed by sexual assault nurse examiners) to Indian victims of domestic violence or sexual abuse;

''(3) to purchase rape kits;

''(4) to develop prevention and intervention models, which may incorporate traditional health care practices; and

''(5) to identify and provide behavioral health treatment to perpetrators who are Indian or members of an Indian household.

''(c) TRAINING AND CERTIFICATION.—

''(1) IN GENERAL.—Not later than 1 year after the date of enactment of the Indian Health Care Improvement Act Amendments of 2009, the Secretary shall establish appropriate protocols, policies, procedures, standards of practice, and, if not available elsewhere, training curricula and training and certification requirements for services for victims of domestic violence and sexual abuse.

''(2) REPORT.—Not later than 18 months after the date of enactment of the Indian Health Care Improvement Act Amendments of 2008, the Secretary shall submit to the Committee on Indian Affairs of

the Senate and the Committee on Natural Resources of the House of Representatives a report that describes the means and extent to which the Secretary has carried out paragraph (1).

''(d) COORDINATION.—

''(1) IN GENERAL.—The Secretary, in coordination with the Attorney General, Federal and tribal law enforcement agencies, Indian Health Programs, and domestic violence or sexual assault victim organizations, shall develop appropriate victim services and victim advocate training programs—

''(A) to improve domestic violence or sexual abuse responses;

''(B) to improve forensic examinations and collection;

''(C) to identify problems or obstacles in the prosecution of domestic violence or sexual abuse; and

''(D) to meet other needs or carry out other activities required to prevent, treat, and improve prosecutions of domestic violence and sexual abuse.

''(2) REPORT.—Not later than 2 years after the date of enactment of the Indian Health Care Improvement Act Amendments of 2008, the Secretary

shall submit to the Committee on Indian Affairs of the Senate and the Committee on Natural Resources of the House of Representatives a report that describes, with respect to the matters described in paragraph (1), the improvements made and needed, problems or obstacles identified, and costs necessary to address the problems or obstacles, and any other recommendations that the Secretary determines to be appropriate.

''SEC. 715. BEHAVIORAL HEALTH RESEARCH.

''The Secretary, in consultation with appropriate Federal agencies, shall make grants to, or enter into contracts with, Indian Tribes, Tribal Organizations, and urban Indian organizations or enter into contracts with, or make grants to appropriate institutions for, the conduct of research on the incidence and prevalence of behavioral health problems among Indians served by the Service, Indian Tribes, or Tribal Organizations and among Indians in urban areas. Research priorities under this section shall include—

''(1) the multifactorial causes of Indian youth suicide, including—

''(A) protective and risk factors and scientific data that identifies those factors; and

''(B) the effects of loss of cultural identity and the development of scientific data on those effects;

''(2) the interrelationship and interdependence of behavioral health problems with alcoholism and other substance abuse, suicide, homicides, other injuries, and the incidence of family violence; and

''(3) the development of models of prevention techniques.

The effect of the interrelationships and interdependencies referred to in paragraph (2) on children, and the development of prevention techniques under paragraph (3) applicable to children, shall be emphasized.

''SEC. 716. DEFINITIONS.

''For the purpose of this title, the following definitions shall apply:

''(1) ASSESSMENT.—The term 'assessment' means the systematic collection, analysis, and dissemination of information on health status, health needs, and health problems.

''(2) ALCOHOL-RELATED NEURODEVELOPMENTAL DISORDERS OR ARND.—The term 'alcohol-related neurodevelopmental disorders' or 'ARND' means, with a history of maternal alcohol consumption during pregnancy, central nervous

system involvement such as developmental delay, intellectual deficit, or neurologic abnormalities. Behaviorally, there can be problems with irritability, and failure to thrive as infants. As children become older there will likely be hyperactivity, attention deficit, language dysfunction, and perceptual and judgment problems.

''(3) BEHAVIORAL HEALTH AFTERCARE.—The term 'behavioral health aftercare' includes those activities and resources used to support recovery following inpatient, residential, intensive substance abuse, or mental health outpatient or outpatient treatment. The purpose is to help prevent or deal with relapse by ensuring that by the time a client or patient is discharged from a level of care, such as outpatient treatment, an aftercare plan has been developed with the client. An aftercare plan may use such resources as a community-based therapeutic group, transitional living facilities, a 12-step sponsor, a local 12-step or other related support group, and other community-based providers.

''(4) DUAL DIAGNOSIS.—The term 'dual diagnosis' means coexisting substance abuse and mental illness conditions or diagnosis. Such clients are

sometimes referred to as mentally ill chemical abusers (MICAs).

''(5) FETAL ALCOHOL SPECTRUM DISORDERS.—

''(A) IN GENERAL.—The term 'fetal alcohol spectrum disorders' includes a range of effects that can occur in an individual whose mother drank alcohol during pregnancy, including physical, mental, behavioral, and/or learning disabilities with possible lifelong implications.

''(B) INCLUSIONS.—The term 'fetal alcohol spectrum disorders' may include—

''(i) fetal alcohol syndrome (FAS);

''(ii) fetal alcohol effect (FAE);

''(iii) alcohol-related birth defects; and

''(iv) alcohol-related neurodevelopmental disorders (ARND).

''(6) FETAL ALCOHOL SYNDROME OR FAS.—The term 'fetal alcohol syndrome' or 'FAS' means any 1 of a spectrum of effects that may occur when a woman drinks alcohol during pregnancy, the diagnosis of which involves the confirmed presence of the following 3 criteria:

''(A) Craniofacial abnormalities.

''(B) Growth deficits.

''(C) Central nervous system abnormalities.

''(7) REHABILITATION.—The term 'rehabilitation' means medical and health care services that—

''(A) are recommended by a physician or licensed practitioner of the healing arts within the scope of their practice under applicable law;

''(B) are furnished in a facility, home, or other setting in accordance with applicable standards; and

''(C) have as their purpose any of the following:

''(i) The maximum attainment of physical, mental, and developmental functioning.

''(ii) Averting deterioration in physical or mental functional status.

''(iii) The maintenance of physical or mental health functional status.

''(8) SUBSTANCE ABUSE.—The term 'substance abuse' includes inhalant abuse.

''(9) SYSTEMS OF CARE.—The term 'Systems of Care' means a system for delivering services to children and their families that is child-centered, family-focused and family-driven, community-based, and culturally competent and responsive to the needs of

the children and families being served. The systems of care approach values prevention and early identification, smooth transitions for children and families, child and family participation and advocacy, comprehensive array of services, individualized service planning, services in the least restrictive environment, and integrated services with coordinated planning across the child-serving systems.

''SEC. 717. AUTHORIZATION OF APPROPRIATIONS.

''There is authorized to be appropriated such sums as may be necessary to carry out the provisions of this title.

''TITLE VIII—MISCELLANEOUS

''SEC. 801. REPORTS.

''For each fiscal year following the date of enactment of the Indian Health Care Improvement Act Amendments of 2009, the Secretary shall transmit to Congress a report containing the following:

''(1) A report on the progress made in meeting the objectives of this Act, including a review of programs established or assisted pursuant to this Act and assessments and recommendations of additional programs or additional assistance necessary to, at a minimum, provide health services to Indians and ensure a health status for Indians, which are at a par-

ity with the health services available to and the health status of the general population.

''(2) A report on whether, and to what extent, new national health care programs, benefits, initiatives, or financing systems have had an impact on the purposes of this Act and any steps that the Secretary may have taken to consult with Indian Tribes, Tribal Organizations, and urban Indian organizations to address such impact, including a report on proposed changes in allocation of funding pursuant to section 807.

''(3) A report on the use of health services by Indians—

''(A) on a national and area or other relevant geographical basis;

''(B) by gender and age;

''(C) by source of payment and type of service;

''(D) comparing such rates of use with rates of use among comparable non-Indian populations; and

''(E) provided under contracts.

''(4) A report of contractors to the Secretary on Health Care Educational Loan Repayments every 6 months required by section 110.

''(5) A general audit report of the Secretary on the Health Care Educational Loan Repayment Program as required by section 110(m).

''(6) A report of the findings and conclusions of demonstration programs on development of educational curricula for substance abuse counseling as required in section 125(f).

''(7) A separate statement which specifies the amount of funds requested to carry out the provisions of section 201.

''(8) A report of the evaluations of health promotion and disease prevention as required in section 203(c).

''(9) A biennial report to Congress on infectious diseases as required by section 212.

''(10) A report on environmental and nuclear health hazards as required by section 215.

''(11) An annual report on the status of all health care facilities needs as required by section 301(c)(2)(B) and 301(d).

''(12) Reports on safe water and sanitary waste disposal facilities as required by section 302(h).

''(13) An annual report on the expenditure of non-Service funds for renovation as required by sections 304(b)(2).

''(14) A report identifying the backlog of maintenance and repair required at Service and tribal facilities required by section 313(a).

''(15) A report providing an accounting of reimbursement funds made available to the Secretary under titles XVIII, XIX, and XXI of the Social Security Act.

''(16) A report on any arrangements for the sharing of medical facilities or services, as authorized by section 406.

''(17) A report on evaluation and renewal of urban Indian programs under section 505.

''(18) A report on the evaluation of programs as required by section 513(d).

''(19) A report on alcohol and substance abuse as required by section 701(f).

''(20) A report on Indian youth mental health services as required by section 707(h).

''(21) A report on the reallocation of base resources if required by section 807.

''(22) A report on the movement of patients between Service Units, including—

''(A) a list of those Service Units that have a net increase and those that have a net decrease of patients due to patients assigned to

one Service Unit voluntarily choosing to receive service at another Service Unit;

''(B) an analysis of the effect of patient movement on the quality of services for those Service Units experiencing an increase in the number of patients served; and

''(C) what funding changes are necessary to maintain a consistent quality of service at Service Units that have an increase in the number of patients served.

''(23) A report on the extent to which health care facilities of the Service, Indian Tribes, Tribal Organizations, and urban Indian organizations comply with credentialing requirements of the Service or licensure requirements of States.

''SEC. 802. REGULATIONS.

''(a) DEADLINES.—

''(1) PROCEDURES.—Not later than 90 days after the date of enactment of the Indian Health Care Improvement Act Amendments of 2009, the Secretary shall initiate procedures under subchapter III of chapter 5 of title 5, United States Code, to negotiate and promulgate such regulations or amendments thereto that are necessary to carry out this Act, except sections 105, 115, 117, 202, and

409 through 414. The Secretary may promulgate regulations to carry out such sections using the procedures required by chapter 5 of title 5, United States Code (commonly known as the 'Administrative Procedure Act').

''(2) PROPOSED REGULATIONS.—Proposed regulations to implement this Act shall be published in the Federal Register by the Secretary no later than 2 years after the date of enactment of the Indian Health Care Improvement Act Amendments of 2009 and shall have no less than a 120-day comment period.

''(3) FINAL REGULATIONS.—The Secretary shall publish in the Federal Register final regulations to implement this Act by not later than 3 years after the date of enactment of the Indian Health Care Improvement Act Amendments of 2009.

''(b) COMMITTEE.—A negotiated rulemaking committee established pursuant to section 565 of title 5, United States Code, to carry out this section shall have as its members only representatives of the Federal Government and representatives of Indian Tribes, and Tribal Organizations, a majority of whom shall be nominated by and be representatives of Indian Tribes and Tribal Organizations from each Service Area.

''(c) ADAPTATION OF PROCEDURES.—The Secretary shall adapt the negotiated rulemaking procedures to the unique context of self-governance and the government-to-government relationship between the United States and Indian Tribes.

''(d) LACK OF REGULATIONS.—The lack of promulgated regulations shall not limit the effect of this Act.

''SEC. 803. PLAN OF IMPLEMENTATION.

''(a) IN GENERAL.—Not later than 1 year after the date of enactment of the Indian Health Care Improvement Act Amendments of 2009, the Secretary, in consultation with Indian Tribes, Tribal Organizations, and urban Indian organizations, shall submit to Congress a plan explaining the manner and schedule, by title and section, by which the Secretary will implement the provisions of this Act. This consultation may be conducted jointly with the annual budget consultation pursuant to the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.).

''(b) LACK OF PLAN.—The lack of (or failure to submit) such a plan shall not limit the effect, or prevent the implementation, of this Act.

"SEC. 804. LIMITATION ON USE OF FUNDS APPROPRIATED TO INDIAN HEALTH SERVICE.

''Any limitation on the use of funds contained in an Act providing appropriations for the Department for a period with respect to the performance of abortions shall apply for that period with respect to the performance of abortions using funds contained in an Act providing appropriations for the Service.

"SEC. 805. ELIGIBILITY OF CALIFORNIA INDIANS.

''(a) IN GENERAL.—The following California Indians shall be eligible for health services provided by the Service:

''(1) Any member of a federally recognized Indian Tribe.

''(2) Any descendant of an Indian who was residing in California on June 1, 1852, if such descendant—

''(A) is a member of the Indian community served by a local program of the Service; and

''(B) is regarded as an Indian by the community in which such descendant lives.

''(3) Any Indian who holds trust interests in public domain, national forest, or reservation allotments in California.

''(4) Any Indian in California who is listed on the plans for distribution of the assets of rancherias and reservations located within the State of Cali-

fornia under the Act of August 18, 1958 (72 Stat. 619), and any descendant of such an Indian.

''(b) CLARIFICATION.—Nothing in this section may be construed as expanding the eligibility of California Indians for health services provided by the Service beyond the scope of eligibility for such health services that applied on May 1, 1986.

''SEC. 806. HEALTH SERVICES FOR INELIGIBLE PERSONS.

''(a) CHILDREN.—Any individual who—

''(1) has not attained 19 years of age;

''(2) is the natural or adopted child, stepchild, foster child, legal ward, or orphan of an eligible Indian; and

''(3) is not otherwise eligible for health services provided by the Service,

shall be eligible for all health services provided by the Service on the same basis and subject to the same rules that apply to eligible Indians until such individual attains 19 years of age. The existing and potential health needs of all such individuals shall be taken into consideration by the Service in determining the need for, or the allocation of, the health resources of the Service. If such an individual has been determined to be legally incompetent prior to attaining 19 years of age, such individual shall remain

eligible for such services until 1 year after the date of a determination of competency.

''(b) SPOUSES.—Any spouse of an eligible Indian who is not an Indian, or who is of Indian descent but is not otherwise eligible for the health services provided by the Service, shall be eligible for such health services if all such spouses or spouses who are married to members of each Indian Tribe being served are made eligible, as a class, by an appropriate resolution of the governing body of the Indian Tribe or Tribal Organization providing such services. The health needs of persons made eligible under this paragraph shall not be taken into consideration by the Service in determining the need for, or allocation of, its health resources.

''(c) PROVISION OF SERVICES TO OTHER INDIVIDUALS.—

''(1) IN GENERAL.—The Secretary is authorized to provide health services under this subsection through health programs operated directly by the Service to individuals who reside within the Service area of the Service Unit and who are not otherwise eligible for such health services if—

''(A) the Indian Tribes served by such Service Unit request such provision of health services to such individuals; and

''(B) the Secretary and the served Indian Tribes have jointly determined that—

''(i) the provision of such health services will not result in a denial or diminution of health services to eligible Indians; and

''(ii) there is no reasonable alternative health facilities or services, within or without the Service Unit, available to meet the health needs of such individuals.

''(2) ISDEAA PROGRAMS.—In the case of health programs and facilities operated under a contract or compact entered into under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.), the governing body of the Indian Tribe or Tribal Organization providing health services under such contract or compact is authorized to determine whether health services should be provided under such contract to individuals who are not eligible for such health services under any other subsection of this section or under any other provision of law. In making such determinations, the governing body of the Indian Tribe or Tribal Organization shall take into account the considerations described in paragraph (1)(B).

''(3) PAYMENT FOR SERVICES.—

''(A) IN GENERAL.—Persons receiving health services provided by the Service under this subsection shall be liable for payment of such health services under a schedule of charges prescribed by the Secretary which, in the judgment of the Secretary, results in reimbursement in an amount not less than the actual cost of providing the health services. Notwithstanding section 404 of this Act or any other provision of law, amounts collected under this subsection, including Medicare, Medicaid, or SCHIP reimbursements under titles XVIII, XIX, and XXI of the Social Security Act, shall be credited to the account of the program providing the service and shall be used for the purposes listed in section 401(d)(2) and amounts collected under this subsection shall be available for expenditure within such program.

''(B) INDIGENT PEOPLE.—Health services may be provided by the Secretary through the Service under this subsection to an indigent individual who would not be otherwise eligible for such health services but for the provisions of paragraph (1) only if an agreement has been

entered into with a State or local government under which the State or local government agrees to reimburse the Service for the expenses incurred by the Service in providing such health services to such indigent individual.

''(4) REVOCATION OF CONSENT FOR SERVICES.—

''(A) SINGLE TRIBE SERVICE AREA.—In the case of a Service Area which serves only 1 Indian Tribe, the authority of the Secretary to provide health services under paragraph (1) shall terminate at the end of the fiscal year succeeding the fiscal year in which the governing body of the Indian Tribe revokes its concurrence to the provision of such health services.

''(B) MULTITRIBAL SERVICE AREA.—In the case of a multitribal Service Area, the authority of the Secretary to provide health services under paragraph (1) shall terminate at the end of the fiscal year succeeding the fiscal year in which at least 51 percent of the number of Indian Tribes in the Service Area revoke their concurrence to the provisions of such health services.

''(d) OTHER SERVICES.—The Service may provide health services under this subsection to individuals who are not eligible for health services provided by the Service under any other provision of law in order to—

''(1) achieve stability in a medical emergency;

''(2) prevent the spread of a communicable disease or otherwise deal with a public health hazard;

''(3) provide care to non-Indian women pregnant with an eligible Indian's child for the duration of the pregnancy through postpartum; or

''(4) provide care to immediate family members of an eligible individual if such care is directly related to the treatment of the eligible individual.

''(e) HOSPITAL PRIVILEGES FOR PRACTITIONERS.—

''(1) IN GENERAL.—Hospital privileges in health facilities operated and maintained by the Service or operated under a contract or compact pursuant to the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.) may be extended to non-Service health care practitioners who provide services to individuals described in subsection (a), (b), (c), or (d). Such non-Service health care practitioners may, as part of the privileging process, be designated as employees of the Federal Government for purposes of section 1346(b) and

chapter 171 of title 28, United States Code (relating to Federal tort claims) only with respect to acts or omissions which occur in the course of providing services to eligible individuals as a part of the conditions under which such hospital privileges are extended.

''(2) DEFINITION.—For purposes of this subsection, the term 'non-Service health care practitioner' means a practitioner who is not—

''(A) an employee of the Service; or

''(B) an employee of an Indian tribe or tribal organization operating a contract or compact under the Indian Self-Determination and Education Assistance Act or an individual who provides health care services pursuant to a personal services contract with such Indian tribe or tribal organization.

''(f) ELIGIBLE INDIAN.—For purposes of this section, the term 'eligible Indian' means any Indian who is eligible for health services provided by the Service without regard to the provisions of this section.

''SEC. 807. REALLOCATION OF BASE RESOURCES.

''(a) REPORT REQUIRED.—Notwithstanding any other provision of law, any allocation of Service funds for a fiscal year that reduces by 5 percent or more from the

previous fiscal year the funding for any recurring program, project, or activity of a Service Unit may be implemented only after the Secretary has submitted to Congress, under section 801, a report on the proposed change in allocation of funding, including the reasons for the change and its likely effects.

''(b) EXCEPTION.—Subsection (a) shall not apply if the total amount appropriated to the Service for a fiscal year is at least 5 percent less than the amount appropriated to the Service for the previous fiscal year.

''SEC. 808. RESULTS OF DEMONSTRATION PROJECTS.

''The Secretary shall provide for the dissemination to Indian Tribes, Tribal Organizations, and urban Indian organizations of the findings and results of demonstration projects conducted under this Act.

''SEC. 809. PROVISION OF SERVICES IN MONTANA.

''(a) CONSISTENT WITH COURT DECISION.—The Secretary, acting through the Service, shall provide services and benefits for Indians in Montana in a manner consistent with the decision of the United States Court of Appeals for the Ninth Circuit in McNabb for McNabb v. Bowen, 829 F.2d 787 (9th Cir. 1987).

''(b) CLARIFICATION.—The provisions of subsection (a) shall not be construed to be an expression of the sense of Congress on the application of the decision described

in subsection (a) with respect to the provision of services or benefits for Indians living in any State other than Montana.

"SEC. 810. MORATORIUM.

"During the period of the moratorium imposed on implementation of the final rule published in the Federal Register on September 16, 1987, by the Department of Health and Human Services, relating to eligibility for the health care services of the Indian Health Service, the Indian Health Service shall provide services pursuant to the criteria for eligibility for such services that were in effect on September 15, 1987, subject to the provisions of sections 805 and 806, until the Service has submitted to the Committees on Appropriations of the Senate and the House of Representatives a budget request reflecting the increased costs associated with the proposed final rule, and the request has been included in an appropriations Act and enacted into law.

"SEC. 811. SEVERABILITY PROVISIONS.

"If any provision of this Act, any amendment made by the Act, or the application of such provision or amendment to any person or circumstances is held to be invalid, the remainder of this Act, the remaining amendments made by this Act, and the application of such provisions

to persons or circumstances other than those to which it is held invalid, shall not be affected thereby.

"SEC. 812. USE OF PATIENT SAFETY ORGANIZATIONS.

"The Service, an Indian Tribe, Tribal Organization, or urban Indian organization may provide for quality assurance activities through the use of a patient safety organization in accordance with title IX of the Public Health Service Act.

"SEC. 813. CONFIDENTIALITY OF MEDICAL QUALITY ASSURANCE RECORDS; QUALIFIED IMMUNITY FOR PARTICIPANTS.

"(a) CONFIDENTIALITY OF RECORDS.—Medical quality assurance records created by or for any Indian Health Program or a health program of an Urban Indian Organization as part of a medical quality assurance program are confidential and privileged. Such records may not be disclosed to any person or entity, except as provided in subsection (c).

"(b) PROHIBITION ON DISCLOSURE AND TESTIMONY.—

"(1) IN GENERAL.—No part of any medical quality assurance record described in subsection (a) may be subject to discovery or admitted into evidence in any judicial or administrative proceeding, except as provided in subsection (c).

''(2) TESTIMONY.—A person who reviews or creates medical quality assurance records for any Indian Health Program or Urban Indian Organization who participates in any proceeding that reviews or creates such records may not be permitted or required to testify in any judicial or administrative proceeding with respect to such records or with respect to any finding, recommendation, evaluation, opinion, or action taken by such person or body in connection with such records except as provided in this section.

''(c) AUTHORIZED DISCLOSURE AND TESTIMONY.—

''(1) IN GENERAL.—Subject to paragraph (2), a medical quality assurance record described in subsection (a) may be disclosed, and a person referred to in subsection (b) may give testimony in connection with such a record, only as follows:

''(A) To a Federal executive agency or private organization, if such medical quality assurance record or testimony is needed by such agency or organization to perform licensing or accreditation functions related to any Indian Health Program or to a health program of an Urban Indian Organization to perform moni-

toring, required by law, of such program or organization.

''(B) To an administrative or judicial proceeding commenced by a present or former Indian Health Program or Urban Indian Organization provider concerning the termination, suspension, or limitation of clinical privileges of such health care provider.

''(C) To a governmental board or agency or to a professional health care society or organization, if such medical quality assurance record or testimony is needed by such board, agency, society, or organization to perform licensing, credentialing, or the monitoring of professional standards with respect to any health care provider who is or was an employee of any Indian Health Program or Urban Indian Organization.

''(D) To a hospital, medical center, or other institution that provides health care services, if such medical quality assurance record or testimony is needed by such institution to assess the professional qualifications of any health care provider who is or was an employee of any Indian Health Program or Urban Indian Orga-

nization and who has applied for or been granted authority or employment to provide health care services in or on behalf of such program or organization.

''(E) To an officer, employee, or contractor of the Indian Health Program or Urban Indian Organization that created the records or for which the records were created. If that officer, employee, or contractor has a need for such record or testimony to perform official duties.

''(F) To a criminal or civil law enforcement agency or instrumentality charged under applicable law with the protection of the public health or safety, if a qualified representative of such agency or instrumentality makes a written request that such record or testimony be provided for a purpose authorized by law.

''(G) In an administrative or judicial proceeding commenced by a criminal or civil law enforcement agency or instrumentality referred to in subparagraph (F), but only with respect to the subject of such proceeding.

''(2) IDENTITY OF PARTICIPANTS.—With the exception of the subject of a quality assurance action, the identity of any person receiving health care

services from any Indian Health Program or Urban Indian Organization or the identity of any other person associated with such program or organization for purposes of a medical quality assurance program that is disclosed in a medical quality assurance record described in subsection (a) shall be deleted from that record or document before any disclosure of such record is made outside such program or organization.

''(d) DISCLOSURE FOR CERTAIN PURPOSES.—

''(1) IN GENERAL.—Nothing in this section shall be construed as authorizing or requiring the withholding from any person or entity aggregate statistical information regarding the results of any Indian Health Program or Urban Indian Organizations's medical quality assurance programs.

''(2) WITHHOLDING FROM CONGRESS.—Nothing in this section shall be construed as authority to withhold any medical quality assurance record from a committee of either House of Congress, any joint committee of Congress, or the Government Accountability Office if such record pertains to any matter within their respective jurisdictions.

''(e) PROHIBITION ON DISCLOSURE OF RECORD OR TESTIMONY.—A person or entity having possession of or

access to a record or testimony described by this section may not disclose the contents of such record or testimony in any manner or for any purpose except as provided in this section.

''(f) EXEMPTION FROM FREEDOM OF INFORMATION ACT.—Medical quality assurance records described in subsection (a) may not be made available to any person under section 552 of title 5, United States Code.

''(g) LIMITATION ON CIVIL LIABILITY.—A person who participates in or provides information to a person or body that reviews or creates medical quality assurance records described in subsection (a) shall not be civilly liable for such participation or for providing such information if the participation or provision of information was in good faith based on prevailing professional standards at the time the medical quality assurance program activity took place.

''(h) APPLICATION TO INFORMATION IN CERTAIN OTHER RECORDS.—Nothing in this section shall be construed as limiting access to the information in a record created and maintained outside a medical quality assurance program, including a patient's medical records, on the grounds that the information was presented during meetings of a review body that are part of a medical quality assurance program.

''(i) REGULATIONS.—The Secretary, acting through the Service, shall promulgate regulations pursuant to section 802.

''(j) DEFINITIONS.—In this section:

''(1) The term 'health care provider' means any health care professional, including community health aides and practitioners certified under section 121, who are granted clinical practice privileges or employed to provide health care services in an Indian Health Program or health program of an Urban Indian Organization, who is licensed or certified to perform health care services by a governmental board or agency or professional health care society or organization.

''(2) The term 'medical quality assurance program' means any activity carried out before, on, or after the date of enactment of this Act by or for any Indian Health Program or Urban Indian Organization to assess the quality of medical care, including activities conducted by or on behalf of individuals, Indian Health Program or Urban Indian Organization medical or dental treatment review committees, or other review bodies responsible for quality assurance, credentials, infection control, patient safety, patient care assessment (including treatment proce-

dures, blood, drugs, and therapeutics), medical records, health resources management review and identification and prevention of medical or dental incidents and risks.

''(3) The term 'medical quality assurance record' means the proceedings, records, minutes, and reports that emanate from quality assurance program activities described in paragraph (2) and are produced or compiled by or for an Indian Health Program or Urban Indian Organization as part of a medical quality assurance program.

''(k) CONTINUED PROTECTION.—Disclosure under subsection (c) does not permit redisclosure except to the extent such further disclosure is authorized under subsection (c) or is otherwise authorized to be disclosed under this section.

''(l) INCONSISTENCIES.—To the extent that the protections under the Patient Safety and Quality Improvement Act of 2005 and this section are inconsistent, the provisions of whichever is more protective shall control.

''(m) RELATIONSHIP TO OTHER LAW.—This section shall continue in force and effect, except as otherwise specifically provided in any Federal law enacted after the date of enactment of the Indian Health Care Improvement Act Amendments of 2009.

''SEC. 814. CLAREMORE INDIAN HOSPITAL.

''The Claremore Indian Hospital shall be deemed to be a dependant Indian community for the purposes of section 1151 of title 18, United States Code.

''SEC. 815. SENSE OF CONGRESS REGARDING LAW ENFORCEMENT AND METHAMPHETAMINE ISSUES IN INDIAN COUNTRY.

''It is the sense of Congress that Congress encourages State, local, and Indian tribal law enforcement agencies to enter into memoranda of agreement between and among those agencies for purposes of streamlining law enforcement activities and maximizing the use of limited resources—

''(1) to improve law enforcement services provided to Indian tribal communities; and

''(2) to increase the effectiveness of measures to address problems relating to methamphetamine use in Indian country (as defined in section 1151 of title 18, United States Code).

''SEC. 816. PERMITTING IMPLEMENTATION THROUGH CONTRACTS WITH TRIBAL HEALTH PROGRAMS.

''Nothing in this Act shall be construed as preventing the Secretary from—

''(1) carrying out any section of this Act through contracts with Tribal Health Programs; and

''(2) carrying out sections through 214, 701(a)(1), 701(b)(1), 701(c), 707(g), and 712(b), through contracts with urban Indian organizations. The previous sentence shall not affect the authority the Secretary may otherwise have to carry out other provisions of this Act through such contracts.

''SEC. 817. AUTHORIZATION OF APPROPRIATIONS; AVAILABILITY.

''(a) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as may be necessary to carry out this title.

''(b) LIMITATION ON NEW SPENDING AUTHORITY.—Any new spending authority (described in subparagraph (A) or (B) of section 401(c)(2) of the Congressional Budget Act of 1974 (Public Law 93–344; 88 Stat. 317)) which is provided under this Act shall be effective for any fiscal year only to such extent or in such amounts as are provided in appropriation Acts.

''(c) AVAILABILITY.—The funds appropriated pursuant to this Act shall remain available until expended.''.

(b) RATE OF PAY.—

(1) POSITIONS AT LEVEL IV.—Section 5315 of title 5, United States Code, is amended by striking ''Assistant Secretaries of Health and Human Serv-

ices (6).'' and inserting ''Assistant Secretaries of Health and Human Services (7)''.

(2) POSITIONS AT LEVEL V.—Section 5316 of title 5, United States Code, is amended by striking ''Director, Indian Health Service, Department of Health and Human Services''.

(c) AMENDMENTS TO OTHER PROVISIONS OF LAW.—

(1) Section 3307(b)(1)(C) of the Children's Health Act of 2000 (25 U.S.C. 1671 note; Public Law 106–310) is amended by striking ''Director of the Indian Health Service'' and inserting ''Assistant Secretary for Indian Health''.

(2) The Indian Lands Open Dump Cleanup Act of 1994 is amended—

(A) in section 3 (25 U.S.C. 3902)—

(i) by striking paragraph (2);

(ii) by redesignating paragraphs (1), (3), (4), (5), and (6) as paragraphs (4), (5), (2), (6), and (1), respectively, and moving those paragraphs so as to appear in numerical order; and

(iii) by inserting before paragraph (4) (as redesignated by subclause (II)) the following:

''(3) ASSISTANT SECRETARY.—The term 'Assistant Secretary' means the Assistant Secretary for Indian Health.'';

(B) in section 5 (25 U.S.C. 3904), by striking the section designation and heading and inserting the following:

"SEC. 5. AUTHORITY OF ASSISTANT SECRETARY FOR INDIAN HEALTH.";

(C) in section 6(a) (25 U.S.C. 3905(a)), in the subsection heading, by striking ''DIRECTOR'' and inserting ''ASSISTANT SECRETARY'';

(D) in section 9(a) (25 U.S.C. 3908(a)), in the subsection heading, by striking ''DIRECTOR'' and inserting ''ASSISTANT SECRETARY''; and

(E) by striking ''Director'' each place it appears and inserting ''Assistant Secretary''.

(3) Section 5504(d)(2) of the Augustus F. Hawkins-Robert T. Stafford Elementary and Secondary School Improvement Amendments of 1988 (25 U.S.C. 2001 note; Public Law 100–297) is amended by striking ''Director of the Indian Health Service'' and inserting ''Assistant Secretary for Indian Health''.

(4) Section 203(a)(1) of the Rehabilitation Act of 1973 (29 U.S.C. 763(a)(1)) is amended by striking ''Director of the Indian Health Service'' and inserting ''Assistant Secretary for Indian Health''.

(5) Subsections (b) and (e) of section 518 of the Federal Water Pollution Control Act (33 U.S.C. 1377) are amended by striking ''Director of the Indian Health Service'' each place it appears and inserting ''Assistant Secretary for Indian Health''.

(6) Section 317M(b) of the Public Health Service Act (42 U.S.C. 247b–14(b)) is amended—

(A) by striking ''Director of the Indian Health Service'' each place it appears and inserting ''Assistant Secretary for Indian Health''; and

(B) in paragraph (2)(A), by striking ''the Directors referred to in such paragraph'' and inserting ''the Director of the Centers for Disease Control and Prevention and the Assistant Secretary for Indian Health''.

(7) Section 417C(b) of the Public Health Service Act (42 U.S.C. 285–9(b)) is amended by striking ''Director of the Indian Health Service'' and inserting ''Assistant Secretary for Indian Health''.

(8) Section 1452(i) of the Safe Drinking Water Act (42 U.S.C. 300j–12(i)) is amended by striking ''Director of the Indian Health Service'' each place it appears and inserting ''Assistant Secretary for Indian Health''.

(9) Section 803B(d)(1) of the Native American Programs Act of 1974 (42 U.S.C. 2991b–2(d)(1)) is amended in the last sentence by striking ''Director of the Indian Health Service'' and inserting ''Assistant Secretary for Indian Health''.

(10) Section 203(b) of the Michigan Indian Land Claims Settlement Act (Public Law 105–143; 111 Stat. 2666) is amended by striking ''Director of the Indian Health Service'' and inserting ''Assistant Secretary for Indian Health''.

SEC. 3102. SOBOBA SANITATION FACILITIES.

The Act of December 17, 1970 (84 Stat. 1465), is amended by adding at the end the following:

''SEC. 9. Nothing in this Act shall preclude the Soboba Band of Mission Indians and the Soboba Indian Reservation from being provided with sanitation facilities and services under the authority of section 7 of the Act of August 5, 1954 (68 Stat. 674), as amended by the Act of July 31, 1959 (73 Stat. 267).''.

SEC. 3103. NATIVE AMERICAN HEALTH AND WELLNESS FOUNDATION.

(a) IN GENERAL.—The Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.) is amended by adding at the end the following:

"TITLE VIII—NATIVE AMERICAN HEALTH AND WELLNESS FOUNDATION

"SEC. 801. DEFINITIONS.

''In this title:

''(1) BOARD.—The term 'Board' means the Board of Directors of the Foundation.

''(2) COMMITTEE.—The term 'Committee' means the Committee for the Establishment of Native American Health and Wellness Foundation established under section 802(f).

''(3) FOUNDATION.—The term 'Foundation' means the Native American Health and Wellness Foundation established under section 802.

''(4) SECRETARY.—The term 'Secretary' means the Secretary of Health and Human Services.

''(5) SERVICE.—The term 'Service' means the Indian Health Service of the Department of Health and Human Services.

"SEC. 802. NATIVE AMERICAN HEALTH AND WELLNESS FOUNDATION.

''(a) ESTABLISHMENT.—

''(1) IN GENERAL.—As soon as practicable after the date of enactment of this title, the Secretary shall establish, under the laws of the District of Columbia and in accordance with this title, the Native American Health and Wellness Foundation.

''(2) FUNDING DETERMINATIONS.—No funds, gift, property, or other item of value (including any interest accrued on such an item) acquired by the Foundation shall—

''(A) be taken into consideration for purposes of determining Federal appropriations relating to the provision of health care and services to Indians; or

''(B) otherwise limit, diminish, or affect the Federal responsibility for the provision of health care and services to Indians.

''(b) PERPETUAL EXISTENCE.—The Foundation shall have perpetual existence.

''(c) NATURE OF CORPORATION.—The Foundation—

''(1) shall be a charitable and nonprofit federally chartered corporation; and

''(2) shall not be an agency or instrumentality of the United States.

''(d) PLACE OF INCORPORATION AND DOMICILE.—The Foundation shall be incorporated and domiciled in the District of Columbia.

''(e) DUTIES.—The Foundation shall—

''(1) encourage, accept, and administer private gifts of real and personal property, and any income from or interest in such gifts, for the benefit of, or in support of, the mission of the Service;

''(2) undertake and conduct such other activities as will further the health and wellness activities and opportunities of Native Americans; and

''(3) participate with and assist Federal, State, and tribal governments, agencies, entities, and individuals in undertaking and conducting activities that will further the health and wellness activities and opportunities of Native Americans.

''(f) COMMITTEE FOR THE ESTABLISHMENT OF NATIVE AMERICAN HEALTH AND WELLNESS FOUNDATION.—

''(1) IN GENERAL.—The Secretary shall establish the Committee for the Establishment of Native American Health and Wellness Foundation to assist the Secretary in establishing the Foundation.

''(2) DUTIES.—Not later than 180 days after the date of enactment of this section, the Committee shall—

''(A) carry out such activities as are necessary to incorporate the Foundation under the laws of the District of Columbia, including acting as incorporators of the Foundation;

''(B) ensure that the Foundation qualifies for and maintains the status required to carry out this section, until the Board is established;

''(C) establish the constitution and initial bylaws of the Foundation;

''(D) provide for the initial operation of the Foundation, including providing for temporary or interim quarters, equipment, and staff; and

''(E) appoint the initial members of the Board in accordance with the constitution and initial bylaws of the Foundation.

''(g) BOARD OF DIRECTORS.—

''(1) IN GENERAL.—The Board of Directors shall be the governing body of the Foundation.

''(2) POWERS.—The Board may exercise, or provide for the exercise of, the powers of the Foundation.

''(3) SELECTION.—

''(A) IN GENERAL.—Subject to subparagraph (B), the number of members of the Board, the manner of selection of the members (including the filling of vacancies), and the terms of office of the members shall be as provided in the constitution and bylaws of the Foundation.

''(B) REQUIREMENTS.—

''(i) NUMBER OF MEMBERS.—The Board shall have at least 11 members, who shall have staggered terms.

''(ii) INITIAL VOTING MEMBERS.—The initial voting members of the Board—

''(I) shall be appointed by the Committee not later than 180 days after the date on which the Foundation is established; and

''(II) shall have staggered terms.

''(iii) QUALIFICATION.—The members of the Board shall be United States citizens who are knowledgeable or experienced in Native American health care and related matters.

''(C) COMPENSATION.—A member of the Board shall not receive compensation for service as a member, but shall be reimbursed for actual and necessary travel and subsistence expenses incurred in the performance of the duties of the Foundation.

''(h) OFFICERS.—

''(1) IN GENERAL.—The officers of the Foundation shall be—

''(A) a secretary, elected from among the members of the Board; and

''(B) any other officers provided for in the constitution and bylaws of the Foundation.

''(2) CHIEF OPERATING OFFICER.—The secretary of the Foundation may serve, at the direction of the Board, as the chief operating officer of the Foundation, or the Board may appoint a chief operating officer, who shall serve at the direction of the Board.

''(3) ELECTION.—The manner of election, term of office, and duties of the officers of the Foundation shall be as provided in the constitution and bylaws of the Foundation.

''(i) POWERS.—The Foundation—

''(1) shall adopt a constitution and bylaws for the management of the property of the Foundation and the regulation of the affairs of the Foundation;

''(2) may adopt and alter a corporate seal;

''(3) may enter into contracts;

''(4) may acquire (through a gift or otherwise), own, lease, encumber, and transfer real or personal property as necessary or convenient to carry out the purposes of the Foundation;

''(5) may sue and be sued; and

''(6) may perform any other act necessary and proper to carry out the purposes of the Foundation.

''(j) PRINCIPAL OFFICE.—

''(1) IN GENERAL.—The principal office of the Foundation shall be in the District of Columbia.

''(2) ACTIVITIES; OFFICES.—The activities of the Foundation may be conducted, and offices may be maintained, throughout the United States in accordance with the constitution and bylaws of the Foundation.

''(k) SERVICE OF PROCESS.—The Foundation shall comply with the law on service of process of each State in which the Foundation is incorporated and of each State in which the Foundation carries on activities.

''(l) LIABILITY OF OFFICERS, EMPLOYEES, AND AGENTS.—

''(1) IN GENERAL.—The Foundation shall be liable for the acts of the officers, employees, and agents of the Foundation acting within the scope of their authority.

''(2) PERSONAL LIABILITY.—A member of the Board shall be personally liable only for gross negligence in the performance of the duties of the member.

''(m) RESTRICTIONS.—

''(1) LIMITATION ON SPENDING.—Beginning with the fiscal year following the first full fiscal year during which the Foundation is in operation, the administrative costs of the Foundation shall not exceed the percentage described in paragraph (2) of the sum of—

''(A) the amounts transferred to the Foundation under subsection (o) during the preceding fiscal year; and

''(B) donations received from private sources during the preceding fiscal year.

''(2) PERCENTAGES.—The percentages referred to in paragraph (1) are—

''(A) for the first fiscal year described in that paragraph, 20 percent;

''(B) for the following fiscal year, 15 percent; and

''(C) for each fiscal year thereafter, 10 percent.

''(3) APPOINTMENT AND HIRING.—The appointment of officers and employees of the Foundation shall be subject to the availability of funds.

''(4) STATUS.—A member of the Board or officer, employee, or agent of the Foundation shall not by reason of association with the Foundation be considered to be an officer, employee, or agent of the United States.

''(n) AUDITS.—The Foundation shall comply with section 10101 of title 36, United States Code, as if the Foundation were a corporation under part B of subtitle II of that title.

''(o) FUNDING.—

''(1) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out subsection (e)(1) $500,000 for each fiscal year, as adjusted to reflect changes in the Consumer Price Index for all-urban consumers published by the Department of Labor.

''(2) TRANSFER OF DONATED FUNDS.—The Secretary shall transfer to the Foundation funds held by the Department of Health and Human Services under the Act of August 5, 1954 (42 U.S.C. 2001 et seq.), if the transfer or use of the funds is not prohibited by any term under which the funds were donated.

''SEC. 803. ADMINISTRATIVE SERVICES AND SUPPORT.

''(a) PROVISION OF SUPPORT BY SECRETARY.—Subject to subsection (b), during the 5-year period beginning on the date on which the Foundation is established, the Secretary—

''(1) may provide personnel, facilities, and other administrative support services to the Foundation;

''(2) may provide funds for initial operating costs and to reimburse the travel expenses of the members of the Board; and

''(3) shall require and accept reimbursements from the Foundation for—

''(A) services provided under paragraph (1); and

''(B) funds provided under paragraph (2).

''(b) REIMBURSEMENT.—Reimbursements accepted under subsection (a)(3)—

''(1) shall be deposited in the Treasury of the United States to the credit of the applicable appropriations account; and

''(2) shall be chargeable for the cost of providing services described in subsection (a)(1) and travel expenses described in subsection (a)(2).

''(c) CONTINUATION OF CERTAIN SERVICES.—The Secretary may continue to provide facilities and necessary support services to the Foundation after the termination of the 5-year period specified in subsection (a) if the facilities and services—

''(1) are available; and

''(2) are provided on reimbursable cost basis.''.

(b) TECHNICAL AMENDMENTS.—The Indian Self-Determination and Education Assistance Act is amended—

(1) by redesignating title V (25 U.S.C. 458bbb et seq.) as title VII;

(2) by redesignating sections 501, 502, and 503 (25 U.S.C. 458bbb, 458bbb–1, 458bbb–2) as sections 701, 702, and 703, respectively; and

(3) in subsection (a)(2) of section 702 and paragraph (2) of section 703 (as redesignated by paragraph (2)), by striking ''section 501'' and inserting ''section 701''.

SEC. 3104. GAO STUDY AND REPORT ON PAYMENTS FOR CONTRACT HEALTH SERVICES.

(a) STUDY.—

(1) IN GENERAL.—The Comptroller General of the United States (in this section referred to as the ''Comptroller General'') shall conduct a study on the utilization of health care furnished by health care providers under the contract health services program funded by the Indian Health Service and operated by the Indian Health Service, an Indian Tribe, or a Tribal Organization (as those terms are defined in section 4 of the Indian Health Care Improvement Act).

(2) ANALYSIS.—The study conducted under paragraph (1) shall include an analysis of—

(A) the amounts reimbursed under the contract health services program described in paragraph (1) for health care furnished by entities, individual providers, and suppliers, including a comparison of reimbursement for such health care through other public programs and in the private sector;

(B) barriers to accessing care under such contract health services program, including, but not limited to, barriers relating to travel distances, cultural differences, and public and pri-

vate sector reluctance to furnish care to patients under such program;

(C) the adequacy of existing Federal funding for health care under such contract health services program; and

(D) any other items determined appropriate by the Comptroller General.

(b) REPORT.—Not later than 18 months after the date of enactment of this Act, the Comptroller General shall submit to Congress a report on the study conducted under subsection (a), together with recommendations regarding—

(1) the appropriate level of Federal funding that should be established for health care under the contract health services program described in subsection (a)(1); and

(2) how to most efficiently utilize such funding.

(c) CONSULTATION.—In conducting the study under subsection (a) and preparing the report under subsection (b), the Comptroller General shall consult with the Indian Health Service, Indian Tribes, and Tribal Organizations.

TITLE II—IMPROVEMENT OF INDIAN HEALTH CARE PROVIDED UNDER THE SOCIAL SECURITY ACT

SEC. 3201. EXPANSION OF PAYMENTS UNDER MEDICARE, MEDICAID, AND SCHIP FOR ALL COVERED SERVICES FURNISHED BY INDIAN HEALTH PROGRAMS.

(a) MEDICAID.—

(1) EXPANSION TO ALL COVERED SERVICES.—Section 1911 of the Social Security Act (42 U.S.C. 1396j) is amended—

(A) by amending the heading to read as follows:

"SEC. 1911. INDIAN HEALTH PROGRAMS.";

and

(B) by amending subsection (a) to read as follows:

''(a) ELIGIBILITY FOR PAYMENT FOR MEDICAL ASSISTANCE.—An Indian Health Program shall be eligible for payment for medical assistance provided under a State plan or under waiver authority with respect to items and services furnished by the Program if the furnishing of such services meets all the conditions and requirements which are applicable generally to the furnishing of items

and services under this title and under such plan or waiver authority.''.

(2) REPEAL OF OBSOLETE PROVISION.—Subsection (b) of such section is repealed.

(3) REVISION OF AUTHORITY TO ENTER INTO AGREEMENTS.—Subsection (c) of such section is amended to read as follows:

''(c) AUTHORITY TO ENTER INTO AGREEMENTS.—The Secretary may enter into an agreement with a State for the purpose of reimbursing the State for medical assistance provided by the Indian Health Service, an Indian Tribe, Tribal Organization, or an Urban Indian Organization (as so defined), directly, through referral, or under contracts or other arrangements between the Indian Health Service, an Indian Tribe, Tribal Organization, or an Urban Indian Organization and another health care provider to Indians who are eligible for medical assistance under the State plan or under waiver authority. This subsection shall not be construed to impair the entitlement of a State to reimbursement for such medical assistance under this title.''.

(4) CROSS-REFERENCES TO SPECIAL FUND FOR IMPROVEMENT OF IHS FACILITIES; DIRECT BILLING OPTION; DEFINITIONS.—Such section is further

amended by striking subsection (d) and adding at the end the following new subsections:

''(c) SPECIAL FUND FOR IMPROVEMENT OF IHS FACILITIES.—For provisions relating to the authority of the Secretary to place payments to which a facility of the Indian Health Service is eligible for payment under this title into a special fund established under section 401(c)(1) of the Indian Health Care Improvement Act, see subparagraphs (A) and (B) of section 401(c)(1) of such Act.

''(d) DIRECT BILLING.—For provisions relating to the authority of an Tribal Health Program to elect to directly bill for, and receive payment for, health care items and services provided by such Program for which payment is made under this title, see section 401(d) of the Indian Health Care Improvement Act.''.

(5) DEFINITIONS.—Section 1101(a) of such Act (42 U.S.C. 1301(a)) is amended by adding at the end the following new paragraph:

''(11) For purposes of this title and titles XVIII, XIX, and XXI, the terms 'Indian Health Program', 'Indian Tribe' (and 'Indian tribe'), 'Tribal Health Program', 'Tribal Organization' (and 'tribal organization'), and 'urban Indian organization' (and 'urban Indian organization') have the meanings

given those terms in section 4 of the Indian Health Care Improvement Act.''.

(b) MEDICARE.—

(1) EXPANSION TO ALL COVERED SERVICES.—Section 1880 of such Act (42 U.S.C. 1395qq) is amended—

(A) by amending the heading to read as follows:

"SEC. 1880. INDIAN HEALTH PROGRAMS.";

and

(B) by amending subsection (a) to read as follows:

''(a) ELIGIBILITY FOR PAYMENTS.—Subject to subsection (e), an Indian Health Program shall be eligible for payments under this title with respect to items and services furnished by the Program if the furnishing of such services meets all the conditions and requirements which are applicable generally to the furnishing of items and services under this title.''.

(2) REPEAL OF OBSOLETE PROVISION.—Subsection (b) of such section is repealed.

(3) CROSS-REFERENCES TO SPECIAL FUND FOR IMPROVEMENT OF IHS FACILITIES; DIRECT BILLING OPTION; DEFINITIONS.—

(A) IN GENERAL.—Such section is further amended by striking subsections (c) and (d) and inserting the following new subsections:

''(b) SPECIAL FUND FOR IMPROVEMENT OF IHS FACILITIES.—For provisions relating to the authority of the Secretary to place payments to which a facility of the Indian Health Service is eligible for payment under this title into a special fund established under section 401(c)(1) of the Indian Health Care Improvement Act, and the requirement to use amounts paid from such fund for making improvements in accordance with subsection (b), see subparagraphs (A) and (B) of section 401(c)(1) of such Act.

''(c) DIRECT BILLING.—For provisions relating to the authority of a Tribal Health Program to elect to directly bill for, and receive payment for, health care items and services provided by such Program for which payment is made under this title, see section 401(d) of the Indian Health Care Improvement Act.''.

(B) CONFORMING AMENDMENTS.—Such section is further amended—

(i) in subsection (e)(3), by striking ''Subsection (c)'' and inserting ''Subsection (b) and section 401(b)(1) of the Indian Health Care Improvement Act'';

(ii) by redesignating subsection (e) as subsection (d); and

(iii) by striking subsection (f).

(4) DEFINITIONS.—Such section is further amended by amending adding at the end the following new subsection:

''(e) DEFINITIONS.—In this section, the terms 'Indian Health Program', 'Indian Tribe', 'Service Unit', 'Tribal Health Program', 'Tribal Organization', and 'Urban Indian Organization' have the meanings given those terms in section 4 of the Indian Health Care Improvement Act.''.

(c) APPLICATION TO SCHIP.—Section 2107(e)(1) of the Social Security Act (42 U.S.C. 1397gg(e)(1)) is amended—

(1) by redesignating subparagraphs (K) through (M) as subparagraphs (L) through (N), respectively; and

(2) by inserting after subparagraph (J), the following new subparagraph:

''(K) Section 1911 (relating to Indian Health Programs, other than subsection (c) of such section).''.

SEC. 3202. ADDITIONAL PROVISIONS TO INCREASE OUTREACH TO, AND ENROLLMENT OF, INDIANS IN SCHIP AND MEDICAID.

(a) ASSURANCE OF PAYMENTS TO INDIAN HEALTH CARE PROVIDERS FOR CHILD HEALTH ASSISTANCE.—Section 2102(b)(3)(D) of the Social Security Act (42 U.S.C. 1397bb(b)(3)(D)) is amended by striking ''(as defined in section 4(c) of the Indian Health Care Improvement Act, 25 U.S.C. 1603(c))'' and inserting '', including how the State will ensure that payments are made to Indian Health Programs and urban Indian organizations operating in the State for the provision of such assistance''.

(b) INCLUSION OF OTHER INDIAN FINANCED HEALTH CARE PROGRAMS IN EXEMPTION FROM PROHIBITION ON CERTAIN PAYMENTS.—Section 2105(c)(6)(B) of such Act (42 U.S.C. 1397ee(c)(6)(B)) is amended by striking ''insurance program, other than an insurance program operated or financed by the Indian Health Service'' and inserting ''program, other than a health care program operated or financed by the Indian Health Service or by an Indian Tribe, Tribal Organization, or urban Indian organization''.

(c) DEFINITIONS.—Section 2110(c) of such Act (42 U.S.C. 1397jj(c)) is amended by adding at the end the following new paragraph:

''(9) INDIAN; INDIAN HEALTH PROGRAM; INDIAN TRIBE; ETC.—The terms 'Indian', 'Indian Health Program', 'Indian Tribe', 'Tribal Organization', and 'Urban Indian Organization' have the meanings given those terms in section 4 of the Indian Health Care Improvement Act.''.

SEC. 3203. SOLICITATION OF PROPOSALS FOR SAFE HARBORS UNDER THE SOCIAL SECURITY ACT FOR FACILITIES OF INDIAN HEALTH PROGRAMS AND URBAN INDIAN ORGANIZATIONS.

The Secretary of Health and Human Services, acting through the Office of the Inspector General of the Department of Health and Human Services, shall publish a notice, described in section 1128D(a)(1)(A) of the Social Security Act (42 U.S.C. 1320a–7d(a)(1)(A)), soliciting a proposal, not later than July 1, 2010, on the development of safe harbors described in such section relating to health care items and services provided by facilities of Indian Health Programs or an urban Indian organization (as such terms are defined in section 4 of the Indian Health Care Improvement Act). Such a safe harbor may relate to areas such as transportation, housing, or cost-sharing, assistance provided through such facilities or contract health services for Indians.

SEC. 3204. ANNUAL REPORT ON INDIANS SERVED BY SOCIAL SECURITY ACT HEALTH BENEFIT PROGRAMS.

Section 1139 of the Social Security Act (42 U.S.C. 1320b–9), as amended by the sections 3203 and 3204, is amended by redesignating subsection (e) as subsection (f), and inserting after subsection (d) the following new subsection:

''(e) ANNUAL REPORT ON INDIANS SERVED BY HEALTH BENEFIT PROGRAMS FUNDED UNDER THIS ACT.—Beginning January 1, 2011, and annually thereafter, the Secretary, acting through the Administrator of the Centers for Medicare & Medicaid Services and the Director of the Indian Health Service, shall submit a report to Congress regarding the enrollment and health status of Indians receiving items or services under health benefit programs funded under this Act during the preceding year. Each such report shall include the following:

''(1) The total number of Indians enrolled in, or receiving items or services under, such programs, disaggregated with respect to each such program.

''(2) The number of Indians described in paragraph (1) that also received health benefits under programs funded by the Indian Health Service.

''(3) General information regarding the health status of the Indians described in paragraph (1),

disaggregated with respect to specific diseases or conditions and presented in a manner that is consistent with protections for privacy of individually identifiable health information under section 264(c) of the Health Insurance Portability and Accountability Act of 1996.

''(4) A detailed statement of the status of facilities of the Indian Health Service or an Indian Tribe, Tribal Organization, or an Urban Indian Organization with respect to such facilities' compliance with the applicable conditions and requirements of titles XVIII, XIX, and XXI, and, in the case of title XIX or XXI, under a State plan under such title or under waiver authority, and of the progress being made by such facilities (under plans submitted under 1911(b) or otherwise) toward the achievement and maintenance of such compliance.

''(5) Such other information as the Secretary determines is appropriate.''.

SEC. 3205. DEVELOPMENT OF RECOMMENDATIONS TO IMPROVE INTERSTATE COORDINATION OF MEDICAID AND SCHIP COVERAGE OF INDIAN CHILDREN AND OTHER CHILDREN WHO ARE OUTSIDE OF THEIR STATE OF RESIDENCY BECAUSE OF EDUCATIONAL OR OTHER NEEDS.

(a) STUDY.—The Secretary shall conduct a study to identify barriers to interstate coordination of enrollment and coverage under the Medicaid program under title XIX of the Social Security Act and the State Children's Health Insurance Program under title XXI of such Act of children who are eligible for medical assistance or child health assistance under such programs and who, because of educational needs, migration of families, emergency evacuations, or otherwise, frequently change their State of residency or otherwise are temporarily present outside of the State of their residency. Such study shall include an examination of the enrollment and coverage coordination issues faced by Indian children who are eligible for medical assistance or child health assistance under such programs in their State of residence and who temporarily reside in an out-of-State boarding school or peripheral dormitory funded by the Bureau of Indian Affairs.

(b) REPORT.—Not later than 18 months after the date of enactment of this Act, the Secretary, in consultation with directors of State Medicaid programs under title

XIX of the Social Security Act and directors of State Children's Health Insurance Programs under title XXI of such Act, shall submit a report to Congress that contains recommendations for such legislative and administrative actions as the Secretary determines appropriate to address the enrollment and coverage coordination barriers identified through the study required under subsection (a).