

AMENDMENT NO. \_\_\_\_\_ Calendar No. \_\_\_\_\_

Purpose: To improve the bill.

**IN THE SENATE OF THE UNITED STATES—111th Cong., 1st Sess.**

**H. R. 3590**

To amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes.

Referred to the Committee on \_\_\_\_\_ and  
ordered to be printed

Ordered to lie on the table and to be printed

AMENDMENT intended to be proposed by  
\_\_\_\_\_ to the amendment (No. 2786)  
proposed by Mr. REID

Viz:

- 1 On page 2074, strike lines 22 through 25, and insert
- 2 the following:
- 3 (f) EFFECTIVE DATE.—The amendments made by
- 4 subsections (a) through (d) of this section shall apply to
- 5 amounts paid or incurred after December 31, 2008, in
- 6 taxable years beginning after such date.

1 **TITLE X—STRENGTHENING**  
2 **QUALITY, AFFORDABLE**  
3 **HEALTH CARE FOR ALL**  
4 **AMERICANS**

5 **Subtitle A—Provisions Relating to**  
6 **Title I**

7 **SEC. 10101. AMENDMENTS TO SUBTITLE A.**

8 (a) Section 2711 of the Public Health Service Act,  
9 as added by section 1001(5) of this Act, is amended to  
10 read as follows:

11 **“SEC. 2711. NO LIFETIME OR ANNUAL LIMITS.**

12 “(a) PROHIBITION.—

13 “(1) IN GENERAL.—A group health plan and a  
14 health insurance issuer offering group or individual  
15 health insurance coverage may not establish—

16 “(A) lifetime limits on the dollar value of  
17 benefits for any participant or beneficiary; or

18 “(B) except as provided in paragraph (2),  
19 annual limits on the dollar value of benefits for  
20 any participant or beneficiary.

21 “(2) ANNUAL LIMITS PRIOR TO 2014.—With re-  
22 spect to plan years beginning prior to January 1,  
23 2014, a group health plan and a health insurance  
24 issuer offering group or individual health insurance  
25 coverage may only establish a restricted annual limit

1 on the dollar value of benefits for any participant or  
2 beneficiary with respect to the scope of benefits that  
3 are essential health benefits under section 1302(b)  
4 of the Patient Protection and Affordable Care Act,  
5 as determined by the Secretary. In defining the term  
6 ‘restricted annual limit’ for purposes of the pre-  
7 ceding sentence, the Secretary shall ensure that ac-  
8 cess to needed services is made available with a  
9 minimal impact on premiums.

10 “(b) PER BENEFICIARY LIMITS.—Subsection (a)  
11 shall not be construed to prevent a group health plan or  
12 health insurance coverage from placing annual or lifetime  
13 per beneficiary limits on specific covered benefits that are  
14 not essential health benefits under section 1302(b) of the  
15 Patient Protection and Affordable Care Act, to the extent  
16 that such limits are otherwise permitted under Federal or  
17 State law.”.

18 (b) Section 2715(a) of the Public Health Service Act,  
19 as added by section 1001(5) of this Act, is amended by  
20 striking “and providing to enrollees” and inserting “and  
21 providing to applicants, enrollees, and policyholders or cer-  
22 tificate holders”.

23 (c) Subpart II of part A of title XXVII of the Public  
24 Health Service Act, as added by section 1001(5), is  
25 amended by inserting after section 2715, the following:

1 **“SEC. 2715A. PROVISION OF ADDITIONAL INFORMATION.**

2 “A group health plan and a health insurance issuer  
3 offering group or individual health insurance coverage  
4 shall comply with the provisions of section 1311(e)(3) of  
5 the Patient Protection and Affordable Care Act, except  
6 that a plan or coverage that is not offered through an Ex-  
7 change shall only be required to submit the information  
8 required to the Secretary and the State insurance commis-  
9 sioner, and make such information available to the pub-  
10 lic.”.

11 (d) Section 2716 of the Public Health Service Act,  
12 as added by section 1001(5) of this Act, is amended to  
13 read as follows:

14 **“SEC. 2716. PROHIBITION ON DISCRIMINATION IN FAVOR**  
15 **OF HIGHLY COMPENSATED INDIVIDUALS.**

16 “(a) IN GENERAL.—A group health plan (other than  
17 a self-insured plan) shall satisfy the requirements of sec-  
18 tion 105(h)(2) of the Internal Revenue Code of 1986 (re-  
19 lating to prohibition on discrimination in favor of highly  
20 compensated individuals).

21 “(b) RULES AND DEFINITIONS.—For purposes of  
22 this section—

23 “(1) CERTAIN RULES TO APPLY.—Rules similar  
24 to the rules contained in paragraphs (3), (4), and  
25 (8) of section 105(h) of such Code shall apply.

1           “(2) HIGHLY COMPENSATED INDIVIDUAL.—The  
2           term ‘highly compensated individual’ has the mean-  
3           ing given such term by section 105(h)(5) of such  
4           Code.”.

5           (e) Section 2717 of the Public Health Service Act,  
6           as added by section 1001(5) of this Act, is amended—

7           (1) by redesignating subsections (c) and (d) as  
8           subsections (d) and (e), respectively; and

9           (2) by inserting after subsection (b), the fol-  
10          lowing:

11          “(c) PROTECTION OF SECOND AMENDMENT GUN  
12          RIGHTS.—

13           “(1) WELLNESS AND PREVENTION PRO-  
14           GRAMS.—A wellness and health promotion activity  
15           implemented under subsection (a)(1)(D) may not re-  
16           quire the disclosure or collection of any information  
17           relating to—

18           “(A) the presence or storage of a lawfully-  
19           possessed firearm or ammunition in the resi-  
20           dence or on the property of an individual; or

21           “(B) the lawful use, possession, or storage  
22           of a firearm or ammunition by an individual.

23           “(2) LIMITATION ON DATA COLLECTION.—None  
24           of the authorities provided to the Secretary under  
25           the Patient Protection and Affordable Care Act or

1 an amendment made by that Act shall be construed  
2 to authorize or may be used for the collection of any  
3 information relating to—

4 “(A) the lawful ownership or possession of  
5 a firearm or ammunition;

6 “(B) the lawful use of a firearm or ammu-  
7 nition; or

8 “(C) the lawful storage of a firearm or am-  
9 munition.

10 “(3) LIMITATION ON DATABASES OR DATA  
11 BANKS.—None of the authorities provided to the  
12 Secretary under the Patient Protection and Afford-  
13 able Care Act or an amendment made by that Act  
14 shall be construed to authorize or may be used to  
15 maintain records of individual ownership or posses-  
16 sion of a firearm or ammunition.

17 “(4) LIMITATION ON DETERMINATION OF PRE-  
18 MIUM RATES OR ELIGIBILITY FOR HEALTH INSUR-  
19 ANCE.—A premium rate may not be increased,  
20 health insurance coverage may not be denied, and a  
21 discount, rebate, or reward offered for participation  
22 in a wellness program may not be reduced or with-  
23 held under any health benefit plan issued pursuant  
24 to or in accordance with the Patient Protection and

1 Affordable Care Act or an amendment made by that  
2 Act on the basis of, or on reliance upon—

3 “(A) the lawful ownership or possession of  
4 a firearm or ammunition; or

5 “(B) the lawful use or storage of a firearm  
6 or ammunition.

7 “(5) LIMITATION ON DATA COLLECTION RE-  
8 QUIREMENTS FOR INDIVIDUALS.—No individual  
9 shall be required to disclose any information under  
10 any data collection activity authorized under the Pa-  
11 tient Protection and Affordable Care Act or an  
12 amendment made by that Act relating to—

13 “(A) the lawful ownership or possession of  
14 a firearm or ammunition; or

15 “(B) the lawful use, possession, or storage  
16 of a firearm or ammunition.”.

17 (f) Section 2718 of the Public Health Service Act,  
18 as added by section 1001(5), is amended to read as fol-  
19 lows:

20 **“SEC. 2718. BRINGING DOWN THE COST OF HEALTH CARE**  
21 **COVERAGE.**

22 “(a) CLEAR ACCOUNTING FOR COSTS.—A health in-  
23 surance issuer offering group or individual health insur-  
24 ance coverage (including a grandfathered health plan)  
25 shall, with respect to each plan year, submit to the Sec-

1   retary a report concerning the ratio of the incurred loss  
2   (or incurred claims) plus the loss adjustment expense (or  
3   change in contract reserves) to earned premiums. Such re-  
4   port shall include the percentage of total premium rev-  
5   enue, after accounting for collections or receipts for risk  
6   adjustment and risk corridors and payments of reinsur-  
7   ance, that such coverage expends—

8           “(1) on reimbursement for clinical services pro-  
9   vided to enrollees under such coverage;

10           “(2) for activities that improve health care  
11   quality; and

12           “(3) on all other non-claims costs, including an  
13   explanation of the nature of such costs, and exclud-  
14   ing Federal and State taxes and licensing or regu-  
15   latory fees.

16   The Secretary shall make reports received under this sec-  
17   tion available to the public on the Internet website of the  
18   Department of Health and Human Services.

19           “(b) ENSURING THAT CONSUMERS RECEIVE VALUE  
20   FOR THEIR PREMIUM PAYMENTS.—

21           “(1) REQUIREMENT TO PROVIDE VALUE FOR  
22   PREMIUM PAYMENTS.—

23           “(A) REQUIREMENT.—Beginning not later  
24   than January 1, 2011, a health insurance  
25   issuer offering group or individual health insur-

1           ance coverage (including a grandfathered health  
2           plan) shall, with respect to each plan year, pro-  
3           vide an annual rebate to each enrollee under  
4           such coverage, on a pro rata basis, if the ratio  
5           of the amount of premium revenue expended by  
6           the issuer on costs described in paragraphs (1)  
7           and (2) of subsection (a) to the total amount of  
8           premium revenue (excluding Federal and State  
9           taxes and licensing or regulatory fees and after  
10          accounting for payments or receipts for risk ad-  
11          justment, risk corridors, and reinsurance under  
12          sections 1341, 1342, and 1343 of the Patient  
13          Protection and Affordable Care Act) for the  
14          plan year (except as provided in subparagraph  
15          (B)(ii)), is less than—

16                   “(i) with respect to a health insurance  
17                   issuer offering coverage in the large group  
18                   market, 85 percent, or such higher per-  
19                   centage as a State may by regulation de-  
20                   termine; or

21                   “(ii) with respect to a health insur-  
22                   ance issuer offering coverage in the small  
23                   group market or in the individual market,  
24                   80 percent, or such higher percentage as a  
25                   State may by regulation determine, except

1 that the Secretary may adjust such per-  
2 centage with respect to a State if the Sec-  
3 retary determines that the application of  
4 such 80 percent may destabilize the indi-  
5 vidual market in such State.

6 “(B) REBATE AMOUNT.—

7 “(i) CALCULATION OF AMOUNT.—The  
8 total amount of an annual rebate required  
9 under this paragraph shall be in an  
10 amount equal to the product of—

11 “(I) the amount by which the  
12 percentage described in clause (i) or  
13 (ii) of subparagraph (A) exceeds the  
14 ratio described in such subparagraph;  
15 and

16 “(II) the total amount of pre-  
17 mium revenue (excluding Federal and  
18 State taxes and licensing or regu-  
19 latory fees and after accounting for  
20 payments or receipts for risk adjust-  
21 ment, risk corridors, and reinsurance  
22 under sections 1341, 1342, and 1343  
23 of the Patient Protection and Afford-  
24 able Care Act) for such plan year.

1                   “(ii) CALCULATION BASED ON AVER-  
2                   AGE RATIO.—Beginning on January 1,  
3                   2014, the determination made under sub-  
4                   paragraph (A) for the year involved shall  
5                   be based on the averages of the premiums  
6                   expended on the costs described in such  
7                   subparagraph and total premium revenue  
8                   for each of the previous 3 years for the  
9                   plan.

10                  “(2) CONSIDERATION IN SETTING PERCENT-  
11                  AGES.—In determining the percentages under para-  
12                  graph (1), a State shall seek to ensure adequate par-  
13                  ticipation by health insurance issuers, competition in  
14                  the health insurance market in the State, and value  
15                  for consumers so that premiums are used for clinical  
16                  services and quality improvements.

17                  “(3) ENFORCEMENT.—The Secretary shall pro-  
18                  mulgate regulations for enforcing the provisions of  
19                  this section and may provide for appropriate pen-  
20                  alties.

21                  “(c) DEFINITIONS.—Not later than December 31,  
22                  2010, and subject to the certification of the Secretary, the  
23                  National Association of Insurance Commissioners shall es-  
24                  tablish uniform definitions of the activities reported under  
25                  subsection (a) and standardized methodologies for calcu-

1 lating measures of such activities, including definitions of  
2 which activities, and in what regard such activities, con-  
3 stitute activities described in subsection (a)(2). Such  
4 methodologies shall be designed to take into account the  
5 special circumstances of smaller plans, different types of  
6 plans, and newer plans.

7 “(d) ADJUSTMENTS.—The Secretary may adjust the  
8 rates described in subsection (b) if the Secretary deter-  
9 mines appropriate on account of the volatility of the indi-  
10 vidual market due to the establishment of State Ex-  
11 changes.

12 “(e) STANDARD HOSPITAL CHARGES.—Each hospital  
13 operating within the United States shall for each year es-  
14 tablish (and update) and make public (in accordance with  
15 guidelines developed by the Secretary) a list of the hos-  
16 pital’s standard charges for items and services provided  
17 by the hospital, including for diagnosis-related groups es-  
18 tablished under section 1886(d)(4) of the Social Security  
19 Act.”.

20 (g) Section 2719 of the Public Health Service Act,  
21 as added by section 1001(4) of this Act, is amended to  
22 read as follows:

23 **“SEC. 2719. APPEALS PROCESS.**

24 “(a) INTERNAL CLAIMS APPEALS.—

1           “(1) IN GENERAL.—A group health plan and a  
2 health insurance issuer offering group or individual  
3 health insurance coverage shall implement an effective  
4 appeals process for appeals of coverage determinations and claims, under which the plan or issuer  
5 shall, at a minimum—  
6

7           “(A) have in effect an internal claims appeal process;  
8

9           “(B) provide notice to enrollees, in a culturally and linguistically appropriate manner, of  
10 available internal and external appeals processes, and the availability of any applicable office of health insurance consumer assistance or  
11 ombudsman established under section 2793 to  
12 assist such enrollees with the appeals processes;  
13 and  
14

15           “(C) allow an enrollee to review their file,  
16 to present evidence and testimony as part of the  
17 appeals process, and to receive continued coverage pending the outcome of the appeals process.  
18  
19  
20  
21

22           “(2) ESTABLISHED PROCESSES.—To comply  
23 with paragraph (1)—

24           “(A) a group health plan and a health insurance issuer offering group health coverage  
25

1 shall provide an internal claims and appeals  
2 process that initially incorporates the claims  
3 and appeals procedures (including urgent  
4 claims) set forth at section 2560.503-1 of title  
5 29, Code of Federal Regulations, as published  
6 on November 21, 2000 (65 Fed. Reg. 70256),  
7 and shall update such process in accordance  
8 with any standards established by the Secretary  
9 of Labor for such plans and issuers; and

10 “(B) a health insurance issuer offering in-  
11 dividual health coverage, and any other issuer  
12 not subject to subparagraph (A), shall provide  
13 an internal claims and appeals process that ini-  
14 tially incorporates the claims and appeals proce-  
15 dures set forth under applicable law (as in ex-  
16 istence on the date of enactment of this sec-  
17 tion), and shall update such process in accord-  
18 ance with any standards established by the Sec-  
19 retary of Health and Human Services for such  
20 issuers.

21 “(b) EXTERNAL REVIEW.—A group health plan and  
22 a health insurance issuer offering group or individual  
23 health insurance coverage—

24 “(1) shall comply with the applicable State ex-  
25 ternal review process for such plans and issuers

1 that, at a minimum, includes the consumer protec-  
2 tions set forth in the Uniform External Review  
3 Model Act promulgated by the National Association  
4 of Insurance Commissioners and is binding on such  
5 plans; or

6 “(2) shall implement an effective external re-  
7 view process that meets minimum standards estab-  
8 lished by the Secretary through guidance and that is  
9 similar to the process described under paragraph  
10 (1)—

11 “(A) if the applicable State has not estab-  
12 lished an external review process that meets the  
13 requirements of paragraph (1); or

14 “(B) if the plan is a self-insured plan that  
15 is not subject to State insurance regulation (in-  
16 cluding a State law that establishes an external  
17 review process described in paragraph (1)).

18 “(c) SECRETARY AUTHORITY.—The Secretary may  
19 deem the external review process of a group health plan  
20 or health insurance issuer, in operation as of the date of  
21 enactment of this section, to be in compliance with the  
22 applicable process established under subsection (b), as de-  
23 termined appropriate by the Secretary.”.

24 (h) Subpart II of part A of title XVIII of the Public  
25 Health Service Act, as added by section 1001(5) of this

1 Act, is amended by inserting after section 2719 the fol-  
2 lowing:

3 **“SEC. 2719A. PATIENT PROTECTIONS.**

4 “(a) CHOICE OF HEALTH CARE PROFESSIONAL.—If  
5 a group health plan, or a health insurance issuer offering  
6 group or individual health insurance coverage, requires or  
7 provides for designation by a participant, beneficiary, or  
8 enrollee of a participating primary care provider, then the  
9 plan or issuer shall permit each participant, beneficiary,  
10 and enrollee to designate any participating primary care  
11 provider who is available to accept such individual.

12 “(b) COVERAGE OF EMERGENCY SERVICES.—

13 “(1) IN GENERAL.—If a group health plan, or  
14 a health insurance issuer offering group or indi-  
15 vidual health insurance issuer, provides or covers  
16 any benefits with respect to services in an emergency  
17 department of a hospital, the plan or issuer shall  
18 cover emergency services (as defined in paragraph  
19 (2)(B))—

20 “(A) without the need for any prior au-  
21 thorization determination;

22 “(B) whether the health care provider fur-  
23 nishing such services is a participating provider  
24 with respect to such services;

1           “(C) in a manner so that, if such services  
2 are provided to a participant, beneficiary, or en-  
3 rollee—

4                   “(i) by a nonparticipating health care  
5 provider with or without prior authoriza-  
6 tion; or

7                   “(ii)(I) such services will be provided  
8 without imposing any requirement under  
9 the plan for prior authorization of services  
10 or any limitation on coverage where the  
11 provider of services does not have a con-  
12 tractual relationship with the plan for the  
13 providing of services that is more restric-  
14 tive than the requirements or limitations  
15 that apply to emergency department serv-  
16 ices received from providers who do have  
17 such a contractual relationship with the  
18 plan; and

19                   “(II) if such services are provided out-  
20 of-network, the cost-sharing requirement  
21 (expressed as a copayment amount or coin-  
22 surance rate) is the same requirement that  
23 would apply if such services were provided  
24 in-network;

1           “(D) without regard to any other term or  
2           condition of such coverage (other than exclusion  
3           or coordination of benefits, or an affiliation or  
4           waiting period, permitted under section 2701 of  
5           this Act, section 701 of the Employee Retirement  
6           Income Security Act of 1974, or section  
7           9801 of the Internal Revenue Code of 1986,  
8           and other than applicable cost-sharing).

9           “(2) DEFINITIONS.—In this subsection:

10           “(A) EMERGENCY MEDICAL CONDITION.—  
11           The term ‘emergency medical condition’ means  
12           a medical condition manifesting itself by acute  
13           symptoms of sufficient severity (including se-  
14           vere pain) such that a prudent layperson, who  
15           possesses an average knowledge of health and  
16           medicine, could reasonably expect the absence  
17           of immediate medical attention to result in a  
18           condition described in clause (i), (ii), or (iii) of  
19           section 1867(e)(1)(A) of the Social Security  
20           Act.

21           “(B) EMERGENCY SERVICES.—The term  
22           ‘emergency services’ means, with respect to an  
23           emergency medical condition—

24                   “(i) a medical screening examination  
25                   (as required under section 1867 of the So-

1           cial Security Act) that is within the capa-  
2           bility of the emergency department of a  
3           hospital, including ancillary services rou-  
4           tinely available to the emergency depart-  
5           ment to evaluate such emergency medical  
6           condition, and

7                   “(ii) within the capabilities of the  
8                   staff and facilities available at the hospital,  
9                   such further medical examination and  
10                  treatment as are required under section  
11                  1867 of such Act to stabilize the patient.

12                  “(C) STABILIZE.—The term ‘to stabilize’,  
13                  with respect to an emergency medical condition  
14                  (as defined in subparagraph (A)), has the  
15                  meaning give in section 1867(e)(3) of the Social  
16                  Security Act (42 U.S.C. 1395dd(e)(3)).

17                  “(c) ACCESS TO PEDIATRIC CARE.—

18                   “(1) PEDIATRIC CARE.—In the case of a person  
19                   who has a child who is a participant, beneficiary, or  
20                   enrollee under a group health plan, or health insur-  
21                   ance coverage offered by a health insurance issuer in  
22                   the group or individual market, if the plan or issuer  
23                   requires or provides for the designation of a partici-  
24                   pating primary care provider for the child, the plan  
25                   or issuer shall permit such person to designate a

1 physician (allopathic or osteopathic) who specializes  
2 in pediatrics as the child’s primary care provider if  
3 such provider participates in the network of the plan  
4 or issuer.

5 “(2) CONSTRUCTION.—Nothing in paragraph  
6 (1) shall be construed to waive any exclusions of cov-  
7 erage under the terms and conditions of the plan or  
8 health insurance coverage with respect to coverage  
9 of pediatric care.

10 “(d) PATIENT ACCESS TO OBSTETRICAL AND GYNE-  
11 COLOGICAL CARE.—

12 “(1) GENERAL RIGHTS.—

13 “(A) DIRECT ACCESS.—A group health  
14 plan, or health insurance issuer offering group  
15 or individual health insurance coverage, de-  
16 scribed in paragraph (2) may not require au-  
17 thorization or referral by the plan, issuer, or  
18 any person (including a primary care provider  
19 described in paragraph (2)(B))) in the case of  
20 a female participant, beneficiary, or enrollee  
21 who seeks coverage for obstetrical or gynecolo-  
22 gical care provided by a participating health  
23 care professional who specializes in obstetrics or  
24 gynecology. Such professional shall agree to  
25 otherwise adhere to such plan’s or issuer’s poli-

1           cies and procedures, including procedures re-  
2           garding referrals and obtaining prior authoriza-  
3           tion and providing services pursuant to a treat-  
4           ment plan (if any) approved by the plan or  
5           issuer.

6           “(B) OBSTETRICAL AND GYNECOLOGICAL  
7           CARE.—A group health plan or health insur-  
8           ance issuer described in paragraph (2) shall  
9           treat the provision of obstetrical and gynecolo-  
10          gical care, and the ordering of related obstet-  
11          rical and gynecological items and services, pur-  
12          suant to the direct access described under sub-  
13          paragraph (A), by a participating health care  
14          professional who specializes in obstetrics or  
15          gynecology as the authorization of the primary  
16          care provider.

17          “(2) APPLICATION OF PARAGRAPH.—A group  
18          health plan, or health insurance issuer offering  
19          group or individual health insurance coverage, de-  
20          scribed in this paragraph is a group health plan or  
21          coverage that—

22                 “(A) provides coverage for obstetric or  
23                 gynecologic care; and

1           “(B) requires the designation by a partici-  
2           pant, beneficiary, or enrollee of a participating  
3           primary care provider.

4           “(3) CONSTRUCTION.—Nothing in paragraph  
5           (1) shall be construed to—

6           “(A) waive any exclusions of coverage  
7           under the terms and conditions of the plan or  
8           health insurance coverage with respect to cov-  
9           erage of obstetrical or gynecological care; or

10           “(B) preclude the group health plan or  
11           health insurance issuer involved from requiring  
12           that the obstetrical or gynecological provider  
13           notify the primary care health care professional  
14           or the plan or issuer of treatment decisions.”.

15           (i) Section 2794 of the Public Health Service Act,  
16           as added by section 1003 of this Act, is amended—

17           (1) in subsection (c)(1)—

18           (A) in subparagraph (A), by striking  
19           “and” at the end;

20           (B) in subparagraph (B), by striking the  
21           period and inserting “; and”; and

22           (C) by adding at the end the following:

23           “(C) in establishing centers (consistent  
24           with subsection (d)) at academic or other non-  
25           profit institutions to collect medical reimburse-

1           ment information from health insurance issuers,  
2           to analyze and organize such information, and  
3           to make such information available to such  
4           issuers, health care providers, health research-  
5           ers, health care policy makers, and the general  
6           public.”; and

7           (2) by adding at the end the following:

8           “(d) MEDICAL REIMBURSEMENT DATA CENTERS.—

9           “(1) FUNCTIONS.—A center established under  
10          subsection (c)(1)(C) shall—

11                 “(A) develop fee schedules and other data-  
12                 base tools that fairly and accurately reflect  
13                 market rates for medical services and the geo-  
14                 graphic differences in those rates;

15                 “(B) use the best available statistical  
16                 methods and data processing technology to de-  
17                 velop such fee schedules and other database  
18                 tools;

19                 “(C) regularly update such fee schedules  
20                 and other database tools to reflect changes in  
21                 charges for medical services;

22                 “(D) make health care cost information  
23                 readily available to the public through an Inter-  
24                 net website that allows consumers to under-  
25                 stand the amounts that health care providers in

1           their area charge for particular medical serv-  
2           ices; and

3           “(E) regularly publish information con-  
4           cerning the statistical methodologies used by  
5           the center to analyze health charge data and  
6           make such data available to researchers and  
7           policy makers.

8           “(2) CONFLICTS OF INTEREST.—A center es-  
9           tablished under subsection (e)(1)(C) shall adopt by-  
10          laws that ensures that the center (and all members  
11          of the governing board of the center) is independent  
12          and free from all conflicts of interest. Such by-laws  
13          shall ensure that the center is not controlled or in-  
14          fluenced by, and does not have any corporate rela-  
15          tion to, any individual or entity that may make or  
16          receive payments for health care services based on  
17          the center’s analysis of health care costs.

18          “(3) RULE OF CONSTRUCTION.—Nothing in  
19          this subsection shall be construed to permit a center  
20          established under subsection (e)(1)(C) to compel  
21          health insurance issuers to provide data to the cen-  
22          ter.”.

23 **SEC. 10102. AMENDMENTS TO SUBTITLE B.**

24          (a) Section 1102(a)(2)(B) of this Act is amended—

1           (1) in the matter preceding clause (i), by strik-  
2           ing “group health benefits plan” and inserting  
3           “group benefits plan providing health benefits”; and

4           (2) in clause (i)(I), by inserting “or any agency  
5           or instrumentality of any of the foregoing” before  
6           the closed parenthetical.

7           (b) Section 1103(a) of this Act is amended—

8           (1) in paragraph (1), by inserting “, or small  
9           business in,” after “residents of any”; and

10          (2) by striking paragraph (2) and inserting the  
11          following:

12           “(2) CONNECTING TO AFFORDABLE COV-  
13           ERAGE.—An Internet website established under  
14           paragraph (1) shall, to the extent practicable, pro-  
15           vide ways for residents of, and small businesses in,  
16           any State to receive information on at least the fol-  
17           lowing coverage options:

18           “(A) Health insurance coverage offered by  
19           health insurance issuers, other than coverage  
20           that provides reimbursement only for the treat-  
21           ment or mitigation of—

22           “(i) a single disease or condition; or

23           “(ii) an unreasonably limited set of  
24           diseases or conditions (as determined by  
25           the Secretary).

1           “(B) Medicaid coverage under title XIX of  
2 the Social Security Act.

3           “(C) Coverage under title XXI of the So-  
4 cial Security Act.

5           “(D) A State health benefits high risk  
6 pool, to the extent that such high risk pool is  
7 offered in such State; and

8           “(E) Coverage under a high risk pool  
9 under section 1101.

10           “(F) Coverage within the small group mar-  
11 ket for small businesses and their employees,  
12 including reinsurance for early retirees under  
13 section 1102, tax credits available under section  
14 45R of the Internal Revenue Code of 1986 (as  
15 added by section 1421), and other information  
16 specifically for small businesses regarding af-  
17 fordable health care options.”.

18 **SEC. 10103. AMENDMENTS TO SUBTITLE C.**

19           (a) Section 2701(a)(5) of the Public Health Service  
20 Act, as added by section 1201(4) of this Act, is amended  
21 by inserting “(other than self-insured group health plans  
22 offered in such market)” after “such market”.

23           (b) Section 2708 of the Public Health Service Act,  
24 as added by section 1201(4) of this Act, is amended by  
25 striking “or individual”.

1 (c) Subpart I of part A of title XXVII of the Public  
2 Health Service Act, as added by section 1201(4) of this  
3 Act, is amended by inserting after section 2708, the fol-  
4 lowing:

5 **“SEC. 2709. COVERAGE FOR INDIVIDUALS PARTICIPATING**  
6 **IN APPROVED CLINICAL TRIALS.**

7 “(a) COVERAGE.—

8 “(1) IN GENERAL.—If a group health plan or  
9 a health insurance issuer offering group or indi-  
10 vidual health insurance coverage provides coverage  
11 to a qualified individual, then such plan or issuer—

12 “(A) may not deny the individual partici-  
13 pation in the clinical trial referred to in sub-  
14 section (b)(2);

15 “(B) subject to subsection (c), may not  
16 deny (or limit or impose additional conditions  
17 on) the coverage of routine patient costs for  
18 items and services furnished in connection with  
19 participation in the trial; and

20 “(C) may not discriminate against the in-  
21 dividual on the basis of the individual’s partici-  
22 pation in such trial.

23 “(2) ROUTINE PATIENT COSTS.—

24 “(A) INCLUSION.—For purposes of para-  
25 graph (1)(B), subject to subparagraph (B), rou-

1           tine patient costs include all items and services  
2           consistent with the coverage provided in the  
3           plan (or coverage) that is typically covered for  
4           a qualified individual who is not enrolled in a  
5           clinical trial.

6           “(B) EXCLUSION.—For purposes of para-  
7           graph (1)(B), routine patient costs does not in-  
8           clude—

9                   “(i) the investigational item, device, or  
10                  service, itself;

11                   “(ii) items and services that are pro-  
12                  vided solely to satisfy data collection and  
13                  analysis needs and that are not used in the  
14                  direct clinical management of the patient;  
15                  or

16                   “(iii) a service that is clearly incon-  
17                  sistent with widely accepted and estab-  
18                  lished standards of care for a particular di-  
19                  agnosis.

20           “(3) USE OF IN-NETWORK PROVIDERS.—If one  
21           or more participating providers is participating in a  
22           clinical trial, nothing in paragraph (1) shall be con-  
23           strued as preventing a plan or issuer from requiring  
24           that a qualified individual participate in the trial  
25           through such a participating provider if the provider

1 will accept the individual as a participant in the  
2 trial.

3 “(4) USE OF OUT-OF-NETWORK.—Notwith-  
4 standing paragraph (3), paragraph (1) shall apply to  
5 a qualified individual participating in an approved  
6 clinical trial that is conducted outside the State in  
7 which the qualified individual resides.

8 “(b) QUALIFIED INDIVIDUAL DEFINED.—For pur-  
9 poses of subsection (a), the term ‘qualified individual’  
10 means an individual who is a participant or beneficiary  
11 in a health plan or with coverage described in subsection  
12 (a)(1) and who meets the following conditions:

13 “(1) The individual is eligible to participate in  
14 an approved clinical trial according to the trial pro-  
15 tocol with respect to treatment of cancer or other  
16 life-threatening disease or condition.

17 “(2) Either—

18 “(A) the referring health care professional  
19 is a participating health care provider and has  
20 concluded that the individual’s participation in  
21 such trial would be appropriate based upon the  
22 individual meeting the conditions described in  
23 paragraph (1); or

24 “(B) the participant or beneficiary pro-  
25 vides medical and scientific information estab-

1           lishing that the individual’s participation in  
2           such trial would be appropriate based upon the  
3           individual meeting the conditions described in  
4           paragraph (1).

5           “(c) LIMITATIONS ON COVERAGE.—This section shall  
6 not be construed to require a group health plan, or a  
7 health insurance issuer offering group or individual health  
8 insurance coverage, to provide benefits for routine patient  
9 care services provided outside of the plan’s (or coverage’s)  
10 health care provider network unless out-of-network bene-  
11 fits are otherwise provided under the plan (or coverage).

12           “(d) APPROVED CLINICAL TRIAL DEFINED.—

13           “(1) IN GENERAL.—In this section, the term  
14 ‘approved clinical trial’ means a phase I, phase II,  
15 phase III, or phase IV clinical trial that is conducted  
16 in relation to the prevention, detection, or treatment  
17 of cancer or other life-threatening disease or condi-  
18 tion and is described in any of the following sub-  
19 paragraphs:

20           “(A) FEDERALLY FUNDED TRIALS.—The  
21 study or investigation is approved or funded  
22 (which may include funding through in-kind  
23 contributions) by one or more of the following:

24           “(i) The National Institutes of  
25 Health.

1                   “(ii) The Centers for Disease Control  
2                   and Prevention.

3                   “(iii) The Agency for Health Care Re-  
4                   search and Quality.

5                   “(iv) The Centers for Medicare &  
6                   Medicaid Services.

7                   “(v) cooperative group or center of  
8                   any of the entities described in clauses (i)  
9                   through (iv) or the Department of Defense  
10                  or the Department of Veterans Affairs.

11                  “(vi) A qualified non-governmental re-  
12                  search entity identified in the guidelines  
13                  issued by the National Institutes of Health  
14                  for center support grants.

15                  “(vii) Any of the following if the con-  
16                  ditions described in paragraph (2) are met:

17                         “(I) The Department of Veterans  
18                         Affairs.

19                         “(II) The Department of De-  
20                         fense.

21                         “(III) The Department of En-  
22                         ergy.

23                         “(B) The study or investigation is con-  
24                         ducted under an investigational new drug appli-

1 cation reviewed by the Food and Drug Adminis-  
2 tration.

3 “(C) The study or investigation is a drug  
4 trial that is exempt from having such an inves-  
5 tigational new drug application.

6 “(2) CONDITIONS FOR DEPARTMENTS.—The  
7 conditions described in this paragraph, for a study  
8 or investigation conducted by a Department, are  
9 that the study or investigation has been reviewed  
10 and approved through a system of peer review that  
11 the Secretary determines—

12 “(A) to be comparable to the system of  
13 peer review of studies and investigations used  
14 by the National Institutes of Health, and

15 “(B) assures unbiased review of the high-  
16 est scientific standards by qualified individuals  
17 who have no interest in the outcome of the re-  
18 view.

19 “(e) LIFE-THREATENING CONDITION DEFINED.—In  
20 this section, the term ‘life-threatening condition’ means  
21 any disease or condition from which the likelihood of death  
22 is probable unless the course of the disease or condition  
23 is interrupted.

1       “(f) CONSTRUCTION.—Nothing in this section shall  
2 be construed to limit a plan’s or issuer’s coverage with  
3 respect to clinical trials.

4       “(g) APPLICATION TO FEHBP.—Notwithstanding  
5 any provision of chapter 89 of title 5, United States Code,  
6 this section shall apply to health plans offered under the  
7 program under such chapter.

8       “(h) PREEMPTION.—Notwithstanding any other pro-  
9 vision of this Act, nothing in this section shall preempt  
10 State laws that require a clinical trials policy for State  
11 regulated health insurance plans that is in addition to the  
12 policy required under this section.”.

13       (d) Section 1251(a) of this Act is amended—

14               (1) in paragraph (2), by striking “With” and  
15 inserting “Except as provided in paragraph (3),  
16 with”; and

17               (2) by adding at the end the following:

18               “(3) APPLICATION OF CERTAIN PROVISIONS.—  
19 The provisions of sections 2715 and 2718 of the  
20 Public Health Service Act (as added by subtitle A)  
21 shall apply to grandfathered health plans for plan  
22 years beginning on or after the date of enactment of  
23 this Act.”.

24       (e) Section 1253 of this Act is amended insert before  
25 the period the following: “, except that—

1           “(1) section 1251 shall take effect on the date  
2 of enactment of this Act; and

3           “(2) the provisions of section 2704 of the Pub-  
4 lic Health Service Act (as amended by section  
5 1201), as they apply to enrollees who are under 19  
6 years of age, shall become effective for plan years  
7 beginning on or after the date that is 6 months after  
8 the date of enactment of this Act.”.

9 (f) Subtitle C of title I of this Act is amended—

10           (1) by redesignating section 1253 as section  
11 1255; and

12           (2) by inserting after section 1252, the fol-  
13 lowing:

14 **“SEC. 1253. ANNUAL REPORT ON SELF-INSURED PLANS.**

15           “Not later than 1 year after the date of enactment  
16 of this Act, and annually thereafter, the Secretary of  
17 Labor shall prepare an aggregate annual report, using  
18 data collected from the Annual Return/Report of Em-  
19 ployee Benefit Plan (Department of Labor Form 5500),  
20 that shall include general information on self-insured  
21 group health plans (including plan type, number of partici-  
22 pants, benefits offered, funding arrangements, and benefit  
23 arrangements) as well as data from the financial filings  
24 of self-insured employers (including information on assets,  
25 liabilities, contributions, investments, and expenses). The

1 Secretary shall submit such reports to the appropriate  
2 committees of Congress.

3 **“SEC. 1254. STUDY OF LARGE GROUP MARKET.**

4 “(a) IN GENERAL.—The Secretary of Health and  
5 Human Services shall conduct a study of the fully-insured  
6 and self-insured group health plan markets to—

7 “(1) compare the characteristics of employers  
8 (including industry, size, and other characteristics as  
9 determined appropriate by the Secretary), health  
10 plan benefits, financial solvency, capital reserve lev-  
11 els, and the risks of becoming insolvent; and

12 “(2) determine the extent to which new insur-  
13 ance market reforms are likely to cause adverse se-  
14 lection in the large group market or to encourage  
15 small and midsize employers to self-insure.

16 “(b) COLLECTION OF INFORMATION.—In conducting  
17 the study under subsection (a), the Secretary, in coordina-  
18 tion with the Secretary of Labor, shall collect information  
19 and analyze—

20 “(1) the extent to which self-insured group  
21 health plans can offer less costly coverage and, if so,  
22 whether lower costs are due to more efficient plan  
23 administration and lower overhead or to the denial  
24 of claims and the offering very limited benefit pack-  
25 ages;

1           “(2) claim denial rates, plan benefit fluctua-  
2           tions (to evaluate the extent that plans scale back  
3           health benefits during economic downturns), and the  
4           impact of the limited recourse options on consumers;  
5           and

6           “(3) any potential conflict of interest as it re-  
7           lates to the health care needs of self-insured enroll-  
8           ees and self-insured employer’s financial contribution  
9           or profit margin, and the impact of such conflict on  
10          administration of the health plan.

11          “(c) REPORT.—Not later than 1 year after the date  
12          of enactment of this Act, the Secretary shall submit to  
13          the appropriate committees of Congress a report con-  
14          cerning the results of the study conducted under sub-  
15          section (a).”.

16          **SEC. 10104. AMENDMENTS TO SUBTITLE D.**

17          (a) Section 1301(a) of this Act is amended by strik-  
18          ing paragraph (2) and inserting the following:

19                  “(2) INCLUSION OF CO-OP PLANS AND MULTI-  
20                  STATE QUALIFIED HEALTH PLANS.—Any reference  
21                  in this title to a qualified health plan shall be  
22                  deemed to include a qualified health plan offered  
23                  through the CO-OP program under section 1322,  
24                  and a multi-State plan under section 1334, unless  
25                  specifically provided for otherwise.

1           “(3) TREATMENT OF QUALIFIED DIRECT PRI-  
2           MARY CARE MEDICAL HOME PLANS.—The Secretary  
3           of Health and Human Services shall permit a quali-  
4           fied health plan to provide coverage through a quali-  
5           fied direct primary care medical home plan that  
6           meets criteria established by the Secretary, so long  
7           as the qualified health plan meets all requirements  
8           that are otherwise applicable and the services cov-  
9           ered by the medical home plan are coordinated with  
10          the entity offering the qualified health plan.

11          “(4) VARIATION BASED ON RATING AREA.—A  
12          qualified health plan, including a multi-State quali-  
13          fied health plan, may as appropriate vary premiums  
14          by rating area (as defined in section 2701(a)(2) of  
15          the Public Health Service Act).”.

16          (b) Section 1302 of this Act is amended—

17                 (1) in subsection (d)(2)(B), by striking “may  
18                 issue” and inserting “shall issue”; and

19                 (2) by adding at the end the following:

20          “(g) PAYMENTS TO FEDERALLY-QUALIFIED HEALTH  
21          CENTERS.—If any item or service covered by a qualified  
22          health plan is provided by a Federally-qualified health cen-  
23          ter (as defined in section 1905(l)(2)(B) of the Social Secu-  
24          rity Act (42 U.S.C. 1396d(l)(2)(B)) to an enrollee of the  
25          plan, the offeror of the plan shall pay to the center for

1 the item or service an amount that is not less than the  
2 amount of payment that would have been paid to the cen-  
3 ter under section 1902(bb) of such Act (42 U.S.C.  
4 1396a(bb)) for such item or service.”.

5 (c) Section 1303 of this Act is amended to read as  
6 follows:

7 **“SEC. 1303. SPECIAL RULES.**

8 “(a) STATE OPT-OUT OF ABORTION COVERAGE.—

9 “(1) IN GENERAL.—A State may elect to pro-  
10 hibit abortion coverage in qualified health plans of-  
11 fered through an Exchange in such State if such  
12 State enacts a law to provide for such prohibition.

13 “(2) TERMINATION OF OPT OUT.—A State may  
14 repeal a law described in paragraph (1) and provide  
15 for the offering of such services through the Ex-  
16 change.

17 “(b) SPECIAL RULES RELATING TO COVERAGE OF  
18 ABORTION SERVICES.—

19 “(1) VOLUNTARY CHOICE OF COVERAGE OF  
20 ABORTION SERVICES.—

21 “(A) IN GENERAL.—Notwithstanding any  
22 other provision of this title (or any amendment  
23 made by this title)—

24 “(i) nothing in this title (or any  
25 amendment made by this title), shall be

1 construed to require a qualified health plan  
2 to provide coverage of services described in  
3 subparagraph (B)(i) or (B)(ii) as part of  
4 its essential health benefits for any plan  
5 year; and

6 “(ii) subject to subsection (a), the  
7 issuer of a qualified health plan shall de-  
8 termine whether or not the plan provides  
9 coverage of services described in subpara-  
10 graph (B)(i) or (B)(ii) as part of such ben-  
11 efits for the plan year.

12 “(B) ABORTION SERVICES.—

13 “(i) ABORTIONS FOR WHICH PUBLIC  
14 FUNDING IS PROHIBITED.—The services  
15 described in this clause are abortions for  
16 which the expenditure of Federal funds ap-  
17 propriated for the Department of Health  
18 and Human Services is not permitted,  
19 based on the law as in effect as of the date  
20 that is 6 months before the beginning of  
21 the plan year involved.

22 “(ii) ABORTIONS FOR WHICH PUBLIC  
23 FUNDING IS ALLOWED.—The services de-  
24 scribed in this clause are abortions for  
25 which the expenditure of Federal funds ap-

1           appropriated for the Department of Health  
2           and Human Services is permitted, based  
3           on the law as in effect as of the date that  
4           is 6 months before the beginning of the  
5           plan year involved.

6           “(2) PROHIBITION ON THE USE OF FEDERAL  
7           FUNDS.—

8           “(A) IN GENERAL.—If a qualified health  
9           plan provides coverage of services described in  
10          paragraph (1)(B)(i), the issuer of the plan shall  
11          not use any amount attributable to any of the  
12          following for purposes of paying for such serv-  
13          ices:

14                 “(i) The credit under section 36B of  
15                 the Internal Revenue Code of 1986 (and  
16                 the amount (if any) of the advance pay-  
17                 ment of the credit under section 1412 of  
18                 the Patient Protection and Affordable Care  
19                 Act).

20                 “(ii) Any cost-sharing reduction under  
21                 section 1402 of the Patient Protection and  
22                 Affordable Care Act (and the amount (if  
23                 any) of the advance payment of the reduc-  
24                 tion under section 1412 of the Patient  
25                 Protection and Affordable Care Act).

1           “(B) ESTABLISHMENT OF ALLOCATION AC-  
2           COUNTS.—In the case of a plan to which sub-  
3           paragraph (A) applies, the issuer of the plan  
4           shall—

5                   “(i) collect from each enrollee in the  
6                   plan (without regard to the enrollee’s age,  
7                   sex, or family status) a separate payment  
8                   for each of the following:

9                           “(I) an amount equal to the por-  
10                           tion of the premium to be paid di-  
11                           rectly by the enrollee for coverage  
12                           under the plan of services other than  
13                           services described in paragraph  
14                           (1)(B)(i) (after reduction for credits  
15                           and cost-sharing reductions described  
16                           in subparagraph (A)); and

17                           “(II) an amount equal to the ac-  
18                           tuarial value of the coverage of serv-  
19                           ices described in paragraph (1)(B)(i),  
20                           and

21                           “(ii) shall deposit all such separate  
22                           payments into separate allocation accounts  
23                           as provided in subparagraph (C).

24           In the case of an enrollee whose premium for  
25           coverage under the plan is paid through em-

1            ployee payroll deposit, the separate payments  
2            required under this subparagraph shall each be  
3            paid by a separate deposit.

4            “(C) SEGREGATION OF FUNDS.—

5            “(i) IN GENERAL.—The issuer of a  
6            plan to which subparagraph (A) applies  
7            shall establish allocation accounts de-  
8            scribed in clause (ii) for enrollees receiving  
9            amounts described in subparagraph (A).

10           “(ii) ALLOCATION ACCOUNTS.—The  
11           issuer of a plan to which subparagraph (A)  
12           applies shall deposit—

13           “(I) all payments described in  
14           subparagraph (B)(i)(I) into a separate  
15           account that consists solely of such  
16           payments and that is used exclusively  
17           to pay for services other than services  
18           described in paragraph (1)(B)(i); and

19           “(II) all payments described in  
20           subparagraph (B)(i)(II) into a sepa-  
21           rate account that consists solely of  
22           such payments and that is used exclu-  
23           sively to pay for services described in  
24           paragraph (1)(B)(i).

25           “(D) ACTUARIAL VALUE.—

1           “(i) IN GENERAL.—The issuer of a  
2           qualified health plan shall estimate the  
3           basic per enrollee, per month cost, deter-  
4           mined on an average actuarial basis, for  
5           including coverage under the qualified  
6           health plan of the services described in  
7           paragraph (1)(B)(i).

8           “(ii) CONSIDERATIONS.—In making  
9           such estimate, the issuer—

10                   “(I) may take into account the  
11                   impact on overall costs of the inclu-  
12                   sion of such coverage, but may not  
13                   take into account any cost reduction  
14                   estimated to result from such services,  
15                   including prenatal care, delivery, or  
16                   postnatal care;

17                   “(II) shall estimate such costs as  
18                   if such coverage were included for the  
19                   entire population covered; and

20                   “(III) may not estimate such a  
21                   cost at less than \$1 per enrollee, per  
22                   month.

23           “(E) ENSURING COMPLIANCE WITH SEG-  
24           REGATION REQUIREMENTS.—

1                   “(i) IN GENERAL.—Subject to clause  
2                   (ii), State health insurance commissioners  
3                   shall ensure that health plans comply with  
4                   the segregation requirements in this sub-  
5                   section through the segregation of plan  
6                   funds in accordance with applicable provi-  
7                   sions of generally accepted accounting re-  
8                   quirements, circulars on funds manage-  
9                   ment of the Office of Management and  
10                  Budget, and guidance on accounting of the  
11                  Government Accountability Office.

12                  “(ii) CLARIFICATION.—Nothing in  
13                  clause (i) shall prohibit the right of an in-  
14                  dividual or health plan to appeal such ac-  
15                  tion in courts of competent jurisdiction.

16                  “(3) RULES RELATING TO NOTICE.—

17                  “(A) NOTICE.—A qualified health plan  
18                  that provides for coverage of the services de-  
19                  scribed in paragraph (1)(B)(i) shall provide a  
20                  notice to enrollees, only as part of the summary  
21                  of benefits and coverage explanation, at the  
22                  time of enrollment, of such coverage.

23                  “(B) RULES RELATING TO PAYMENTS.—  
24                  The notice described in subparagraph (A), any  
25                  advertising used by the issuer with respect to

1 the plan, any information provided by the Ex-  
2 change, and any other information specified by  
3 the Secretary shall provide information only  
4 with respect to the total amount of the com-  
5 bined payments for services described in para-  
6 graph (1)(B)(i) and other services covered by  
7 the plan.

8 “(4) NO DISCRIMINATION ON BASIS OF PROVI-  
9 SION OF ABORTION.—No qualified health plan of-  
10 fered through an Exchange may discriminate against  
11 any individual health care provider or health care fa-  
12 cility because of its unwillingness to provide, pay for,  
13 provide coverage of, or refer for abortions

14 “(c) APPLICATION OF STATE AND FEDERAL LAWS  
15 REGARDING ABORTION.—

16 “(1) NO PREEMPTION OF STATE LAWS REGARD-  
17 ING ABORTION.—Nothing in this Act shall be con-  
18 strued to preempt or otherwise have any effect on  
19 State laws regarding the prohibition of (or require-  
20 ment of) coverage, funding, or procedural require-  
21 ments on abortions, including parental notification  
22 or consent for the performance of an abortion on a  
23 minor.

24 “(2) NO EFFECT ON FEDERAL LAWS REGARD-  
25 ING ABORTION.—

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

4                               “(i) conscience protection;

5                               “(ii) willingness or refusal to provide  
6                   abortion; and

7                               “(iii) discrimination on the basis of  
8                   the willingness or refusal to provide, pay  
9                   for, cover, or refer for abortion or to pro-  
10                  vide or participate in training to provide  
11                  abortion.

12                   “(3) NO EFFECT ON FEDERAL CIVIL RIGHTS  
13                  LAW.—Nothing in this subsection shall alter the  
14                  rights and obligations of employees and employers  
15                  under title VII of the Civil Rights Act of 1964.

16                   “(d) APPLICATION OF EMERGENCY SERVICES  
17                  LAWS.—Nothing in this Act shall be construed to relieve  
18                  any health care provider from providing emergency serv-  
19                  ices as required by State or Federal law, including section  
20                  1867 of the Social Security Act (popularly known as  
21                  ‘EMTALA’).”.

22                   (d) Section 1304 of this Act is amended by adding  
23                  at the end the following:

24                   “(e) EDUCATED HEALTH CARE CONSUMERS.—The  
25                  term ‘educated health care consumer’ means an individual

1 who is knowledgeable about the health care system, and  
2 has background or experience in making informed deci-  
3 sions regarding health, medical, and scientific matters.”.

4 (e) Section 1311(d) of this Act is amended—

5 (1) in paragraph (3)(B), by striking clause (ii)  
6 and inserting the following:

7 “(ii) STATE MUST ASSUME COST.—A

8 State shall make payments—

9 “(I) to an individual enrolled in a  
10 qualified health plan offered in such  
11 State; or

12 “(II) on behalf of an individual  
13 described in subclause (I) directly to  
14 the qualified health plan in which  
15 such individual is enrolled;

16 to defray the cost of any additional bene-  
17 fits described in clause (i).”; and

18 (2) in paragraph (6)(A), by inserting “edu-  
19 cated” before “health care”.

20 (f) Section 1311(e) of this Act is amended—

21 (1) in paragraph (2), by striking “may” in the  
22 second sentence and inserting “shall”; and

23 (2) by adding at the end the following:

24 “(3) TRANSPARENCY IN COVERAGE.—

1           “(A) IN GENERAL.—The Exchange shall  
2 require health plans seeking certification as  
3 qualified health plans to submit to the Ex-  
4 change, the Secretary, the State insurance com-  
5 missioner, and make available to the public, ac-  
6 curate and timely disclosure of the following in-  
7 formation:

8                   “(i) Claims payment policies and  
9 practices.

10                   “(ii) Periodic financial disclosures.

11                   “(iii) Data on enrollment.

12                   “(iv) Data on disenrollment.

13                   “(v) Data on the number of claims  
14 that are denied.

15                   “(vi) Data on rating practices.

16                   “(vii) Information on cost-sharing and  
17 payments with respect to any out-of-net-  
18 work coverage.

19                   “(viii) Information on enrollee and  
20 participant rights under this title.

21                   “(ix) Other information as determined  
22 appropriate by the Secretary.

23           “(B) USE OF PLAIN LANGUAGE.—The in-  
24 formation required to be submitted under sub-  
25 paragraph (A) shall be provided in plain lan-

1 guage. The term ‘plain language’ means lan-  
2 guage that the intended audience, including in-  
3 dividuals with limited English proficiency, can  
4 readily understand and use because that lan-  
5 guage is concise, well-organized, and follows  
6 other best practices of plain language writing.  
7 The Secretary and the Secretary of Labor shall  
8 jointly develop and issue guidance on best prac-  
9 tices of plain language writing.

10 “(C) COST SHARING TRANSPARENCY.—The  
11 Exchange shall require health plans seeking  
12 certification as qualified health plans to permit  
13 individuals to learn the amount of cost-sharing  
14 (including deductibles, copayments, and coin-  
15 surance) under the individual’s plan or coverage  
16 that the individual would be responsible for  
17 paying with respect to the furnishing of a spe-  
18 cific item or service by a participating provider  
19 in a timely manner upon the request of the in-  
20 dividual. At a minimum, such information shall  
21 be made available to such individual through an  
22 Internet website and such other means for indi-  
23 viduals without access to the Internet.

24 “(D) GROUP HEALTH PLANS.—The Sec-  
25 retary of Labor shall update and harmonize the

1 Secretary's rules concerning the accurate and  
2 timely disclosure to participants by group  
3 health plans of plan disclosure, plan terms and  
4 conditions, and periodic financial disclosure  
5 with the standards established by the Secretary  
6 under subparagraph (A).”.

7 (g) Section 1311(g)(1) of this Act is amended—

8 (1) in subparagraph (C), by striking “; and”  
9 and inserting a semicolon;

10 (2) in subparagraph (D), by striking the period  
11 and inserting “; and”; and

12 (3) by adding at the end the following:

13 “(E) the implementation of activities to re-  
14 duce health and health care disparities, includ-  
15 ing through the use of language services, com-  
16 munity outreach, and cultural competency  
17 trainings.”.

18 (h) Section 1311(i)(2)((B) of this Act is amended by  
19 striking “small business development centers” and insert-  
20 ing “resource partners of the Small Business Administra-  
21 tion”.

22 (i) Section 1312 of this Act is amended—

23 (1) in subsection (a)(1), by inserting “and for  
24 which such individual is eligible” before the period;

25 (2) in subsection (e)—

1 (A) in paragraph (1), by inserting “and  
2 employers” after “enroll individuals”; and

3 (B) by striking the flush sentence at the  
4 end; and

5 (3) in subsection (f)(1)(A)(ii), by striking the  
6 parenthetical.

7 (j)(1) Subparagraph (B) of section 1313(a)(6) of this  
8 Act is hereby deemed null, void, and of no effect.

9 (2) Section 3730(e) of title 31, United States Code,  
10 is amended by striking paragraph (4) and inserting the  
11 following:

12 “(4)(A) The court shall dismiss an action or  
13 claim under this section, unless opposed by the Gov-  
14 ernment, if substantially the same allegations or  
15 transactions as alleged in the action or claim were  
16 publicly disclosed—

17 “(i) in a Federal criminal, civil, or admin-  
18 istrative hearing in which the Government or its  
19 agent is a party;

20 “(ii) in a congressional, Government Ac-  
21 countability Office, or other Federal report,  
22 hearing, audit, or investigation; or

23 “(iii) from the news media,

1 unless the action is brought by the Attorney General  
2 or the person bringing the action is an original  
3 source of the information.

4 “(B) For purposes of this paragraph, “original  
5 source” means an individual who either (i) prior to  
6 a public disclosure under subsection (e)(4)(a), has  
7 voluntarily disclosed to the Government the informa-  
8 tion on which allegations or transactions in a claim  
9 are based, or (2) who has knowledge that is inde-  
10 pendent of and materially adds to the publicly dis-  
11 closed allegations or transactions, and who has vol-  
12 untarily provided the information to the Government  
13 before filing an action under this section.”.

14 (k) Section 1313(b) of this Act is amended—

15 (1) in paragraph (3), by striking “and” at the  
16 end;

17 (2) by redesignating paragraph (4) as para-  
18 graph (5); and

19 (3) by inserting after paragraph (3) the fol-  
20 lowing:

21 “(4) a survey of the cost and affordability of  
22 health care insurance provided under the Exchanges  
23 for owners and employees of small business concerns  
24 (as defined under section 3 of the Small Business  
25 Act (15 U.S.C. 632)), including data on enrollees in

1 Exchanges and individuals purchasing health insur-  
2 ance coverage outside of Exchanges; and”.

3 (l) Section 1322(b) of this Act is amended—

4 (1) by redesignating paragraph (3) as para-  
5 graph (4); and

6 (2) by inserting after paragraph (2), the fol-  
7 lowing:

8 “(3) REPAYMENT OF LOANS AND GRANTS.—

9 Not later than July 1, 2013, and prior to awarding  
10 loans and grants under the CO-OP program, the  
11 Secretary shall promulgate regulations with respect  
12 to the repayment of such loans and grants in a man-  
13 ner that is consistent with State solvency regulations  
14 and other similar State laws that may apply. In pro-  
15 mulgating such regulations, the Secretary shall pro-  
16 vide that such loans shall be repaid within 5 years  
17 and such grants shall be repaid within 15 years, tak-  
18 ing into consideration any appropriate State reserve  
19 requirements, solvency regulations, and requisite  
20 surplus note arrangements that must be constructed  
21 in a State to provide for such repayment prior to  
22 awarding such loans and grants.”.

23 (m) Part III of subtitle D of title I of this Act is  
24 amended by striking section 1323.

1 (n) Section 1324(a) of this Act is amended by strik-  
2 ing “, a community health” and all that follows through  
3 “1333(b)” and inserting “, or a multi-State qualified  
4 health plan under section 1334”.

5 (o) Section 1331 of this Act is amended—

6 (1) in subsection (d)(3)(A)(i), by striking “85”  
7 and inserting “95”; and

8 (2) in subsection (e)(1)(B), by inserting before  
9 the semicolon the following: “, or, in the case of an  
10 alien lawfully present in the United States, whose in-  
11 come is not greater than 133 percent of the poverty  
12 line for the size of the family involved but who is not  
13 eligible for the Medicaid program under title XIX of  
14 the Social Security Act by reason of such alien sta-  
15 tus”.

16 (p) Section 1333 of this Act is amended by striking  
17 subsection (b).

18 (q) Part IV of subtitle D of title I of this Act is  
19 amended by adding at the end the following:

20 **“SEC. 1334. MULTI-STATE PLANS.**

21 **“(a) OVERSIGHT BY THE OFFICE OF PERSONNEL**  
22 **MANAGEMENT.—**

23 **“(1) IN GENERAL.—**The Director of the Office  
24 of Personnel Management (referred to in this section  
25 as the ‘Director’) shall enter into contracts with

1 health insurance issuers (which may include a group  
2 of health insurance issuers affiliated either by com-  
3 mon ownership and control or by the common use of  
4 a nationally licensed service mark), without regard  
5 to section 5 of title 41, United States Code, or other  
6 statutes requiring competitive bidding, to offer at  
7 least 2 multi-State qualified health plans through  
8 each Exchange in each State. Such plans shall pro-  
9 vide individual, or in the case of small employers,  
10 group coverage.

11 “(2) TERMS.—Each contract entered into  
12 under paragraph (1) shall be for a uniform term of  
13 at least 1 year, but may be made automatically re-  
14 newable from term to term in the absence of notice  
15 of termination by either party. In entering into such  
16 contracts, the Director shall ensure that health bene-  
17 fits coverage is provided in accordance with the  
18 types of coverage provided for under section  
19 2701(a)(1)(A)(i) of the Public Health Service Act.

20 “(3) NON-PROFIT ENTITIES.—In entering into  
21 contracts under paragraph (1), the Director shall  
22 ensure that at least one contract is entered into with  
23 a non-profit entity.

24 “(4) ADMINISTRATION.—The Director shall im-  
25 plement this subsection in a manner similar to the

1 manner in which the Director implements the con-  
2 tracting provisions with respect to carriers under the  
3 Federal employees health benefit program under  
4 chapter 89 of title 5, United States Code, including  
5 (through negotiating with each multi-state plan)—

6 “(A) a medical loss ratio;

7 “(B) a profit margin;

8 “(C) the premiums to be charged; and

9 “(D) such other terms and conditions of  
10 coverage as are in the interests of enrollees in  
11 such plans.

12 “(5) AUTHORITY TO PROTECT CONSUMERS.—

13 The Director may prohibit the offering of any multi-  
14 State health plan that does not meet the terms and  
15 conditions defined by the Director with respect to  
16 the elements described in subparagraphs (A)  
17 through (D) of paragraph (4).

18 “(6) ASSURED AVAILABILITY OF VARIED COV-  
19 ERAGE.—In entering into contracts under this sub-  
20 section, the Director shall ensure that with respect  
21 to multi-State qualified health plans offered in an  
22 Exchange, there is at least one such plan that does  
23 not provide coverage of services described in section  
24 1303(b)(1)(B)(i).

1           “(7) WITHDRAWAL.—Approval of a contract  
2 under this subsection may be withdrawn by the Di-  
3 rector only after notice and opportunity for hearing  
4 to the issuer concerned without regard to subchapter  
5 II of chapter 5 and chapter 7 of title 5, United  
6 States Code.

7           “(b) ELIGIBILITY.—A health insurance issuer shall  
8 be eligible to enter into a contract under subsection (a)(1)  
9 if such issuer—

10           “(1) agrees to offer a multi-State qualified  
11 health plan that meets the requirements of sub-  
12 section (c) in each Exchange in each State;

13           “(2) is licensed in each State and is subject to  
14 all requirements of State law not inconsistent with  
15 this section, including the standards and require-  
16 ments that a State imposes that do not prevent the  
17 application of a requirement of part A of title  
18 XXVII of the Public Health Service Act or a re-  
19 quirement of this title;

20           “(3) otherwise complies with the minimum  
21 standards prescribed for carriers offering health ben-  
22 efits plans under section 8902(e) of title 5, United  
23 States Code, to the extent that such standards do  
24 not conflict with a provision of this title; and

1           “(4) meets such other requirements as deter-  
2           mined appropriate by the Director, in consultation  
3           with the Secretary.

4           “(c) REQUIREMENTS FOR MULTI-STATE QUALIFIED  
5 HEALTH PLAN.—

6           “(1) IN GENERAL.—A multi-State qualified  
7           health plan meets the requirements of this sub-  
8           section if, in the determination of the Director—

9                   “(A) the plan offers a benefits package  
10                   that is uniform in each State and consists of  
11                   the essential benefits described in section 1302;

12                   “(B) the plan meets all requirements of  
13                   this title with respect to a qualified health plan,  
14                   including requirements relating to the offering  
15                   of the bronze, silver, and gold levels of coverage  
16                   and catastrophic coverage in each State Ex-  
17                   change;

18                   “(C) except as provided in paragraph (5),  
19                   the issuer provides for determinations of pre-  
20                   miums for coverage under the plan on the basis  
21                   of the rating requirements of part A of title  
22                   XXVII of the Public Health Service Act; and

23                   “(D) the issuer offers the plan in all geo-  
24                   graphic regions, and in all States that have

1           adopted adjusted community rating before the  
2           date of enactment of this Act.

3           “(2) STATES MAY OFFER ADDITIONAL BENE-  
4           FITS.—Nothing in paragraph (1)(A) shall preclude a  
5           State from requiring that benefits in addition to the  
6           essential health benefits required under such para-  
7           graph be provided to enrollees of a multi-State quali-  
8           fied health plan offered in such State.

9           “(3) CREDITS.—

10           “(A) IN GENERAL.—An individual enrolled  
11           in a multi-State qualified health plan under this  
12           section shall be eligible for credits under section  
13           36B of the Internal Revenue Code of 1986 and  
14           cost sharing assistance under section 1402 in  
15           the same manner as an individual who is en-  
16           rolled in a qualified health plan.

17           “(B) NO ADDITIONAL FEDERAL COST.—A  
18           requirement by a State under paragraph (2)  
19           that benefits in addition to the essential health  
20           benefits required under paragraph (1)(A) be  
21           provided to enrollees of a multi-State qualified  
22           health plan shall not affect the amount of a  
23           premium tax credit provided under section 36B  
24           of the Internal Revenue Code of 1986 with re-  
25           spect to such plan.

1           “(4) STATE MUST ASSUME COST.—A State  
2 shall make payments—

3           “(A) to an individual enrolled in a multi-  
4 State qualified health plan offered in such  
5 State; or

6           “(B) on behalf of an individual described  
7 in subparagraph (A) directly to the multi-State  
8 qualified health plan in which such individual is  
9 enrolled;

10 to defray the cost of any additional benefits de-  
11 scribed in paragraph (2).

12           “(5) APPLICATION OF CERTAIN STATE RATING  
13 REQUIREMENTS.—With respect to a multi-State  
14 qualified health plan that is offered in a State with  
15 age rating requirements that are lower than 3:1, the  
16 State may require that Exchanges operating in such  
17 State only permit the offering of such multi-State  
18 qualified health plans if such plans comply with the  
19 State’s more protective age rating requirements.

20           “(d) PLANS DEEMED TO BE CERTIFIED.—A multi-  
21 State qualified health plan that is offered under a contract  
22 under subsection (a) shall be deemed to be certified by  
23 an Exchange for purposes of section 1311(d)(4)(A).

24           “(e) PHASE-IN.—Notwithstanding paragraphs (1)  
25 and (2) of subsection (b), the Director shall enter into a

1 contract with a health insurance issuer for the offering  
2 of a multi-State qualified health plan under subsection (a)  
3 if—

4 “(1) with respect to the first year for which the  
5 issuer offers such plan, such issuer offers the plan  
6 in at least 60 percent of the States;

7 “(2) with respect to the second such year, such  
8 issuer offers the plan in at least 70 percent of the  
9 States;

10 “(3) with respect to the third such year, such  
11 issuer offers the plan in at least 85 percent of the  
12 States; and

13 “(4) with respect to each subsequent year, such  
14 issuer offers the plan in all States.

15 “(f) APPLICABILITY.—The requirements under chap-  
16 ter 89 of title 5, United States Code, applicable to health  
17 benefits plans under such chapter shall apply to multi-  
18 State qualified health plans provided for under this section  
19 to the extent that such requirements do not conflict with  
20 a provision of this title.

21 “(g) CONTINUED SUPPORT FOR FEHBP.—

22 “(1) MAINTENANCE OF EFFORT.—Nothing in  
23 this section shall be construed to permit the Director  
24 to allocate fewer financial or personnel resources to  
25 the functions of the Office of Personnel Management

1 related to the administration of the Federal Employ-  
2 ees Health Benefit Program under chapter 89 of  
3 title 5, United States Code.

4 “(2) SEPARATE RISK POOL.—Enrollees in  
5 multi-State qualified health plans under this section  
6 shall be treated as a separate risk pool apart from  
7 enrollees in the Federal Employees Health Benefit  
8 Program under chapter 89 of title 5, United States  
9 Code.

10 “(3) AUTHORITY TO ESTABLISH SEPARATE EN-  
11 TITIES.—The Director may establish such separate  
12 units or offices within the Office of Personnel Man-  
13 agement as the Director determines to be appro-  
14 priate to ensure that the administration of multi-  
15 State qualified health plans under this section does  
16 not interfere with the effective administration of the  
17 Federal Employees Health Benefit Program under  
18 chapter 89 of title 5, United States Code.

19 “(4) EFFECTIVE OVERSIGHT.—The Director  
20 may appoint such additional personnel as may be  
21 necessary to enable the Director to carry out activi-  
22 ties under this section.

23 “(5) ASSURANCE OF SEPARATE PROGRAM.—In  
24 carrying out this section, the Director shall ensure  
25 that the program under this section is separate from

1 the Federal Employees Health Benefit Program  
2 under chapter 89 of title 5, United States Code.  
3 Premiums paid for coverage under a multi-State  
4 qualified health plan under this section shall not be  
5 considered to be Federal funds for any purposes.

6 “(6) FEHBP PLANS NOT REQUIRED TO PAR-  
7 TICIPATE.—Nothing in this section shall require that  
8 a carrier offering coverage under the Federal Em-  
9 ployees Health Benefit Program under chapter 89 of  
10 title 5, United States Code, also offer a multi-State  
11 qualified health plan under this section.

12 “(h) ADVISORY BOARD.—The Director shall establish  
13 an advisory board to provide recommendations on the ac-  
14 tivities described in this section. A significant percentage  
15 of the members of such board shall be comprised of enroll-  
16 ees in a multi-State qualified health plan, or representa-  
17 tives of such enrollees.

18 “(i) AUTHORIZATION OF APPROPRIATIONS.—There is  
19 authorized to be appropriated, such sums as may be nec-  
20 essary to carry out this section.”.

21 (r) Section 1341 of this Act is amended—

22 (1) in the section heading, by striking “**AND**  
23 **SMALL GROUP MARKETS**” and inserting “**MAR-**  
24 **KET**”;

1           (2) in subsection (b)(2)(B), by striking “para-  
2           graph (1)(A)” and inserting “paragraph (1)(B)”;  
3           and

4           (3) in subsection (c)(1)(A), by striking “and  
5           small group markets” and inserting “market”.

6   **SEC. 10105. AMENDMENTS TO SUBTITLE E.**

7           (a) Section 36B(b)(3)(A)(ii) of the Internal Revenue  
8   Code of 1986, as added by section 1401(a) of this Act,  
9   is amended by striking “is in excess of” and inserting  
10 “equals or exceeds”.

11          (b) Section 36B(c)(1)(A) of the Internal Revenue  
12   Code of 1986, as added by section 1401(a) of this Act,  
13   is amended by inserting “equals or” before “exceeds”.

14          (c) Section 36B(c)(2)(C)(iv) of the Internal Revenue  
15   Code of 1986, as added by section 1401(a) of this Act,  
16   is amended by striking “subsection (b)(3)(A)(ii)” and in-  
17   serting “subsection (b)(3)(A)(iii)”.

18          (d) Section 1401(d) of this Act is amended by adding  
19   at the end the following:

20                 “(3) Section 6211(b)(4)(A) of the Internal Rev-  
21   enue Code of 1986 is amended by inserting ‘36B,’  
22   after ‘36A.’”.

23          (e)(1) Subparagraph (B) of section 45R(d)(3) of the  
24   Internal Revenue Code of 1986, as added by section  
25   1421(a) of this Act, is amended to read as follows:

1                   “(B) DOLLAR AMOUNT.—For purposes of  
2 paragraph (1)(B) and subsection (c)(2)—

3                   “(i) 2010, 2011, 2012, AND 2013.—The  
4 dollar amount in effect under this para-  
5 graph for taxable years beginning in 2010,  
6 2011, 2012, or 2013 is \$25,000.

7                   “(ii) SUBSEQUENT YEARS.—In the  
8 case of a taxable year beginning in a cal-  
9 endar year after 2013, the dollar amount  
10 in effect under this paragraph shall be  
11 equal to \$25,000, multiplied by the cost-of-  
12 living adjustment under section 1(f)(3) for  
13 the calendar year, determined by sub-  
14 stituting ‘calendar year 2012’ for ‘calendar  
15 year 1992’ in subparagraph (B) thereof.”.

16           (2) Subsection (g) of section 45R of the Internal Rev-  
17 enue Code of 1986, as added by section 1421(a) of this  
18 Act, is amended by striking “2011” both places it appears  
19 and inserting “2010, 2011”.

20           (3) Section 280C(h) of the Internal Revenue Code of  
21 1986, as added by section 1421(d)(1) of this Act, is  
22 amended by striking “2011” and inserting “2010, 2011”.

23           (4) Section 1421(f) of this Act is amended by striking  
24 “2010” both places it appears and inserting “2009”.



1 to the impact of such disparity on efforts to expand  
2 health coverage and ensure health care.

3 “(2) TERRITORIES DEFINED.—In this sub-  
4 section, the term ‘territories of the United States’  
5 includes the Commonwealth of Puerto Rico, the  
6 United States Virgin Islands, Guam, the Northern  
7 Mariana Islands, and any other territory or posses-  
8 sion of the United States.”.

9 **SEC. 10106. AMENDMENTS TO SUBTITLE F.**

10 (a) Section 1501(a)(2) of this Act is amended to read  
11 as follows:

12 “(2) EFFECTS ON THE NATIONAL ECONOMY  
13 AND INTERSTATE COMMERCE.—The effects de-  
14 scribed in this paragraph are the following:

15 “(A) The requirement regulates activity  
16 that is commercial and economic in nature: eco-  
17 nomic and financial decisions about how and  
18 when health care is paid for, and when health  
19 insurance is purchased. In the absence of the  
20 requirement, some individuals would make an  
21 economic and financial decision to forego health  
22 insurance coverage and attempt to self-insure,  
23 which increases financial risks to households  
24 and medical providers.

1           “(B) Health insurance and health care  
2 services are a significant part of the national  
3 economy. National health spending is projected  
4 to increase from \$2,500,000,000,000, or 17.6  
5 percent of the economy, in 2009 to  
6 \$4,700,000,000,000 in 2019. Private health in-  
7 surance spending is projected to be  
8 \$854,000,000,000 in 2009, and pays for med-  
9 ical supplies, drugs, and equipment that are  
10 shipped in interstate commerce. Since most  
11 health insurance is sold by national or regional  
12 health insurance companies, health insurance is  
13 sold in interstate commerce and claims pay-  
14 ments flow through interstate commerce.

15           “(C) The requirement, together with the  
16 other provisions of this Act, will add millions of  
17 new consumers to the health insurance market,  
18 increasing the supply of, and demand for,  
19 health care services, and will increase the num-  
20 ber and share of Americans who are insured.

21           “(D) The requirement achieves near-uni-  
22 versal coverage by building upon and strength-  
23 ening the private employer-based health insur-  
24 ance system, which covers 176,000,000 Ameri-  
25 cans nationwide. In Massachusetts, a similar re-

1           requirement has strengthened private employer-  
2           based coverage: despite the economic downturn,  
3           the number of workers offered employer-based  
4           coverage has actually increased.

5           “(E) The economy loses up to  
6           \$207,000,000,000 a year because of the poorer  
7           health and shorter lifespan of the uninsured. By  
8           significantly reducing the number of the unin-  
9           sured, the requirement, together with the other  
10          provisions of this Act, will significantly reduce  
11          this economic cost.

12          “(F) The cost of providing uncompensated  
13          care to the uninsured was \$43,000,000,000 in  
14          2008. To pay for this cost, health care pro-  
15          viders pass on the cost to private insurers,  
16          which pass on the cost to families. This cost-  
17          shifting increases family premiums by on aver-  
18          age over \$1,000 a year. By significantly reduc-  
19          ing the number of the uninsured, the require-  
20          ment, together with the other provisions of this  
21          Act, will lower health insurance premiums.

22          “(G) 62 percent of all personal bank-  
23          ruptcies are caused in part by medical expenses.  
24          By significantly increasing health insurance  
25          coverage, the requirement, together with the

1 other provisions of this Act, will improve finan-  
2 cial security for families.

3 “(H) Under the Employee Retirement In-  
4 come Security Act of 1974 (29 U.S.C. 1001 et  
5 seq.), the Public Health Service Act (42 U.S.C.  
6 201 et seq.), and this Act, the Federal Govern-  
7 ment has a significant role in regulating health  
8 insurance. The requirement is an essential part  
9 of this larger regulation of economic activity,  
10 and the absence of the requirement would un-  
11 dercut Federal regulation of the health insur-  
12 ance market.

13 “(I) Under sections 2704 and 2705 of the  
14 Public Health Service Act (as added by section  
15 1201 of this Act), if there were no requirement,  
16 many individuals would wait to purchase health  
17 insurance until they needed care. By signifi-  
18 cantly increasing health insurance coverage, the  
19 requirement, together with the other provisions  
20 of this Act, will minimize this adverse selection  
21 and broaden the health insurance risk pool to  
22 include healthy individuals, which will lower  
23 health insurance premiums. The requirement is  
24 essential to creating effective health insurance  
25 markets in which improved health insurance

1 products that are guaranteed issue and do not  
2 exclude coverage of pre-existing conditions can  
3 be sold.

4 “(J) Administrative costs for private  
5 health insurance, which were \$90,000,000,000  
6 in 2006, are 26 to 30 percent of premiums in  
7 the current individual and small group markets.  
8 By significantly increasing health insurance  
9 coverage and the size of purchasing pools,  
10 which will increase economies of scale, the re-  
11 quirement, together with the other provisions of  
12 this Act, will significantly reduce administrative  
13 costs and lower health insurance premiums.  
14 The requirement is essential to creating effec-  
15 tive health insurance markets that do not re-  
16 quire underwriting and eliminate its associated  
17 administrative costs.”.

18 (b)(1) Section 5000A(b)(1) of the Internal Revenue  
19 Code of 1986, as added by section 1501(b) of this Act,  
20 is amended to read as follows:

21 “(1) IN GENERAL.—If a taxpayer who is an ap-  
22 plicable individual, or an applicable individual for  
23 whom the taxpayer is liable under paragraph (3),  
24 fails to meet the requirement of subsection (a) for  
25 1 or more months, then, except as provided in sub-

1 section (e), there is hereby imposed on the taxpayer  
2 a penalty with respect to such failures in the amount  
3 determined under subsection (c).”.

4 (2) Paragraphs (1) and (2) of section 5000A(c)  
5 of the Internal Revenue Code of 1986, as so added,  
6 are amended to read as follows:

7 “(1) IN GENERAL.—The amount of the penalty  
8 imposed by this section on any taxpayer for any tax-  
9 able year with respect to failures described in sub-  
10 section (b)(1) shall be equal to the lesser of—

11 “(A) the sum of the monthly penalty  
12 amounts determined under paragraph (2) for  
13 months in the taxable year during which 1 or  
14 more such failures occurred, or

15 “(B) an amount equal to the national aver-  
16 age premium for qualified health plans which  
17 have a bronze level of coverage, provide cov-  
18 erage for the applicable family size involved,  
19 and are offered through Exchanges for plan  
20 years beginning in the calendar year with or  
21 within which the taxable year ends.

22 “(2) MONTHLY PENALTY AMOUNTS.—For pur-  
23 poses of paragraph (1)(A), the monthly penalty  
24 amount with respect to any taxpayer for any month  
25 during which any failure described in subsection

1 (b)(1) occurred is an amount equal to  $\frac{1}{12}$  of the  
2 greater of the following amounts:

3 “(A) FLAT DOLLAR AMOUNT.—An amount  
4 equal to the lesser of—

5 “(i) the sum of the applicable dollar  
6 amounts for all individuals with respect to  
7 whom such failure occurred during such  
8 month, or

9 “(ii) 300 percent of the applicable dol-  
10 lar amount (determined without regard to  
11 paragraph (3)(C)) for the calendar year  
12 with or within which the taxable year ends.

13 “(B) PERCENTAGE OF INCOME.—An  
14 amount equal to the following percentage of the  
15 taxpayer’s household income for the taxable  
16 year:

17 “(i) 0.5 percent for taxable years be-  
18 ginning in 2014.

19 “(ii) 1.0 percent for taxable years be-  
20 ginning in 2015.

21 “(iii) 2.0 percent for taxable years be-  
22 ginning after 2015.”.

23 (3) Section 5000A(c)(3) of the Internal Revenue  
24 Code of 1986, as added by section 1501(b) of this Act,  
25 is amended by striking “\$350” and inserting “\$495”.

1 (c) Section 5000A(d)(2)(A) of the Internal Revenue  
2 Code of 1986, as added by section 1501(b) of this Act,  
3 is amended to read as follows:

4 “(A) RELIGIOUS CONSCIENCE EXEMP-  
5 TION.—Such term shall not include any indi-  
6 vidual for any month if such individual has in  
7 effect an exemption under section  
8 1311(d)(4)(H) of the Patient Protection and  
9 Affordable Care Act which certifies that such  
10 individual is—

11 “(i) a member of a recognized reli-  
12 gious sect or division thereof which is de-  
13 scribed in section 1402(g)(1), and

14 “(ii) an adherent of established tenets  
15 or teachings of such sect or division as de-  
16 scribed in such section.”.

17 (d) Section 5000A(e)(1)(C) of the Internal Revenue  
18 Code of 1986, as added by section 1501(b) of this Act,  
19 is amended to read as follows:

20 “(C) SPECIAL RULES FOR INDIVIDUALS  
21 RELATED TO EMPLOYEES.—For purposes of  
22 subparagraph (B)(i), if an applicable individual  
23 is eligible for minimum essential coverage  
24 through an employer by reason of a relationship  
25 to an employee, the determination under sub-

1 paragraph (A) shall be made by reference to re-  
2 quired contribution of the employee.”.

3 (e) Section 4980H(b) of the Internal Revenue Code  
4 of 1986, as added by section 1513(a) of this Act, is  
5 amended to read as follows:

6 “(b) LARGE EMPLOYERS WITH WAITING PERIODS  
7 EXCEEDING 60 DAYS.—

8 “(1) IN GENERAL.—In the case of any applica-  
9 ble large employer which requires an extended wait-  
10 ing period to enroll in any minimum essential cov-  
11 erage under an employer-sponsored plan (as defined  
12 in section 5000A(f)(2)), there is hereby imposed on  
13 the employer an assessable payment of \$600 for  
14 each full-time employee of the employer to whom the  
15 extended waiting period applies.

16 “(2) EXTENDED WAITING PERIOD.—The term  
17 ‘extended waiting period’ means any waiting period  
18 (as defined in section 2701(b)(4) of the Public  
19 Health Service Act) which exceeds 60 days.”.

20 (f)(1) Subparagraph (A) of section 4980H(d)(4) of  
21 the Internal Revenue Code of 1986, as added by section  
22 1513(a) of this Act, is amended by inserting “, with re-  
23 spect to any month,” after “means”.

1           (2) Section 4980H(d)(2) of the Internal Revenue  
2 Code of 1986, as added by section 1513(a) of this Act,  
3 is amended by adding at the end the following:

4                   “(D) APPLICATION TO CONSTRUCTION IN-  
5 DUSTRY EMPLOYERS.—In the case of any em-  
6 ployer the substantial annual gross receipts of  
7 which are attributable to the construction in-  
8 dustry—

9                   “(i) subparagraph (A) shall be applied  
10 by substituting ‘who employed an average  
11 of at least 5 full-time employees on busi-  
12 ness days during the preceding calendar  
13 year and whose annual payroll expenses ex-  
14 ceed \$250,000 for such preceding calendar  
15 year’ for ‘who employed an average of at  
16 least 50 full-time employees on business  
17 days during the preceding calendar year’,  
18 and

19                   “(ii) subparagraph (B) shall be ap-  
20 plied by substituting ‘5’ for ‘50’.”.

21           (3) The amendment made by paragraph (2) shall  
22 apply to months beginning after December 31, 2013.

23           (g) Section 6056(b) of the Internal Revenue Code of  
24 1986, as added by section 1514(a) of the Act, is amended  
25 by adding at the end the following new flush sentence:

1 “The Secretary shall have the authority to review the ac-  
2 curacy of the information provided under this subsection,  
3 including the applicable large employer’s share under  
4 paragraph (2)(C)(iv).”.

5 **SEC. 10107. AMENDMENTS TO SUBTITLE G.**

6 (a) Section 1562 of this Act is amended, in the  
7 amendment made by subsection (a)(2)(B)(iii), by striking  
8 “subpart 1” and inserting “subparts I and II”; and

9 (b) Subtitle G of title I of this Act is amended—

10 (1) by redesignating section 1562 (as amended)  
11 as section 1563; and

12 (2) by inserting after section 1561 the fol-  
13 lowing:

14 **“SEC. 1562. GAO STUDY REGARDING THE RATE OF DENIAL**  
15 **OF COVERAGE AND ENROLLMENT BY**  
16 **HEALTH INSURANCE ISSUERS AND GROUP**  
17 **HEALTH PLANS.**

18 “(a) IN GENERAL.—The Comptroller General of the  
19 United States (referred to in this section as the ‘Comp-  
20 troller General’) shall conduct a study of the incidence of  
21 denials of coverage for medical services and denials of ap-  
22 plications to enroll in health insurance plans, as described  
23 in subsection (b), by group health plans and health insur-  
24 ance issuers.

25 “(b) DATA.—

1           “(1) IN GENERAL.—In conducting the study de-  
2           scribed in subsection (a), the Comptroller General  
3           shall consider samples of data concerning the fol-  
4           lowing:

5                   “(A)(i) denials of coverage for medical  
6                   services to a plan enrollees, by the types of  
7                   services for which such coverage was denied;  
8                   and

9                   “(ii) the reasons such coverage was denied;  
10                  and

11                  “(B)(i) incidents in which group health  
12                  plans and health insurance issuers deny the ap-  
13                  plication of an individual to enroll in a health  
14                  insurance plan offered by such group health  
15                  plan or issuer; and

16                  “(ii) the reasons such applications are de-  
17                  nied.

18           “(2) SCOPE OF DATA.—

19                   “(A) FAVORABLY RESOLVED DISPUTES.—  
20                   The data that the Comptroller General con-  
21                   siders under paragraph (1) shall include data  
22                   concerning denials of coverage for medical serv-  
23                   ices and denials of applications for enrollment  
24                   in a plan by a group health plan or health in-  
25                   surance issuer, where such group health plan or

1 health insurance issuer later approves such cov-  
2 erage or application.

3 “(B) ALL HEALTH PLANS.—The study  
4 under this section shall consider data from var-  
5 ied group health plans and health insurance  
6 plans offered by health insurance issuers, in-  
7 cluding qualified health plans and health plans  
8 that are not qualified health plans.

9 “(c) REPORT.—Not later than one year after the date  
10 of enactment of this Act, the Comptroller General shall  
11 submit to the Secretaries of Health and Human Services  
12 and Labor a report describing the results of the study con-  
13 ducted under this section.

14 “(d) PUBLICATION OF REPORT.—The Secretaries of  
15 Health and Human Services and Labor shall make the  
16 report described in subsection (c) available to the public  
17 on an Internet website.

18 **“SEC. 1563. SMALL BUSINESS PROCUREMENT.**

19 “Part 19 of the Federal Acquisition Regulation, sec-  
20 tion 15 of the Small Business Act (15 U.S.C. 644), and  
21 any other applicable laws or regulations establishing pro-  
22 curement requirements relating to small business concerns  
23 (as defined in section 3 of the Small Business Act (15  
24 U.S.C. 632)) may not be waived with respect to any con-

1 tract awarded under any program or other authority  
2 under this Act or an amendment made by this Act.”.

3 **SEC. 10108. FREE CHOICE VOUCHERS.**

4 (a) IN GENERAL.—An offering employer shall pro-  
5 vide free choice vouchers to each qualified employee of  
6 such employer.

7 (b) OFFERING EMPLOYER.—For purposes of this  
8 section, the term “offering employer” means any employer  
9 who—

10 (1) offers minimum essential coverage to its  
11 employees consisting of coverage through an eligible  
12 employer-sponsored plan; and

13 (2) pays any portion of the costs of such plan.

14 (c) QUALIFIED EMPLOYEE.—For purposes of this  
15 section—

16 (1) IN GENERAL.—The term “qualified em-  
17 ployee” means, with respect to any plan year of an  
18 offering employer, any employee—

19 (A) whose required contribution (as deter-  
20 mined under section 5000A(e)(1)(B)) for min-  
21 imum essential coverage through an eligible em-  
22 ployer-sponsored plan—

23 (i) exceeds 8 percent of such employ-  
24 ee’s household income for the taxable year

1 described in section 1412(b)(1)(B) which  
2 ends with or within in the plan year; and

3 (ii) does not exceed 9.8 percent of  
4 such employee's household income for such  
5 taxable year;

6 (B) whose household income for such tax-  
7 able year is not greater than 400 percent of the  
8 poverty line for a family of the size involved;  
9 and

10 (C) who does not participate in a health  
11 plan offered by the offering employer.

12 (2) INDEXING.—In the case of any calendar  
13 year beginning after 2014, the Secretary shall adjust  
14 the 8 percent under paragraph (1)(A)(i) and 9.8  
15 percent under paragraph (1)(A)(ii) for the calendar  
16 year to reflect the rate of premium growth between  
17 the preceding calendar year and 2013 over the rate  
18 of income growth for such period.

19 (d) FREE CHOICE VOUCHER.—

20 (1) AMOUNT.—

21 (A) IN GENERAL.—The amount of any free  
22 choice voucher provided under subsection (a)  
23 shall be equal to the monthly portion of the cost  
24 of the eligible employer-sponsored plan which  
25 would have been paid by the employer if the

1 employee were covered under the plan with re-  
2 spect to which the employer pays the largest  
3 portion of the cost of the plan. Such amount  
4 shall be equal to the amount the employer  
5 would pay for an employee with self-only cov-  
6 erage unless such employee elects family cov-  
7 erage (in which case such amount shall be the  
8 amount the employer would pay for family cov-  
9 erage).

10 (B) DETERMINATION OF COST.—The cost  
11 of any health plan shall be determined under  
12 the rules similar to the rules of section 2204 of  
13 the Public Health Service Act, except that such  
14 amount shall be adjusted for age and category  
15 of enrollment in accordance with regulations es-  
16 tablished by the Secretary.

17 (2) USE OF VOUCHERS.—An Exchange shall  
18 credit the amount of any free choice voucher pro-  
19 vided under subsection (a) to the monthly premium  
20 of any qualified health plan in the Exchange in  
21 which the qualified employee is enrolled and the of-  
22 fering employer shall pay any amounts so credited to  
23 the Exchange.

24 (3) PAYMENT OF EXCESS AMOUNTS.—If the  
25 amount of the free choice voucher exceeds the

1 amount of the premium of the qualified health plan  
2 in which the qualified employee is enrolled for such  
3 month, such excess shall be paid to the employee.

4 (e) OTHER DEFINITIONS.—Any term used in this  
5 section which is also used in section 5000A of the Internal  
6 Revenue Code of 1986 shall have the meaning given such  
7 term under such section 5000A.

8 (f) EXCLUSION FROM INCOME FOR EMPLOYEE.—

9 (1) IN GENERAL.—Part III of subchapter B of  
10 chapter 1 of the Internal Revenue Code of 1986 is  
11 amended by inserting after section 139C the fol-  
12 lowing new section:

13 **“SEC. 139D. FREE CHOICE VOUCHERS.**

14 “Gross income shall not include the amount of any  
15 free choice voucher provided by an employer under section  
16 10108 of the Patient Protection and Affordable Care Act  
17 to the extent that the amount of such voucher does not  
18 exceed the amount paid for a qualified health plan (as de-  
19 fined in section 1301 of such Act) by the taxpayer.”.

20 (2) CLERICAL AMENDMENT.—The table of sec-  
21 tions for part III of subchapter B of chapter 1 of  
22 such Code is amended by inserting after the item re-  
23 lating to section 139C the following new item:

“Sec. 139D. Free choice vouchers.”.

1           (3) EFFECTIVE DATE.—The amendments made  
2           by this subsection shall apply to vouchers provided  
3           after December 31, 2013.

4           (g) DEDUCTION ALLOWED TO EMPLOYER.—

5           (1) IN GENERAL.—Section 162(a) of the Inter-  
6           nal Revenue Code of 1986 is amended by adding at  
7           the end the following new sentence: “For purposes  
8           of paragraph (1), the amount of a free choice vouch-  
9           er provided under section 10108 of the Patient Pro-  
10          tection and Affordable Care Act shall be treated as  
11          an amount for compensation for personal services  
12          actually rendered.”.

13          (2) EFFECTIVE DATE.—The amendments made  
14          by this subsection shall apply to vouchers provided  
15          after December 31, 2013.

16          (h) VOUCHER TAKEN INTO ACCOUNT IN DETER-  
17          MINING PREMIUM CREDIT.—

18          (1) IN GENERAL.—Subsection (c)(2) of section  
19          36B of the Internal Revenue Code of 1986, as added  
20          by section 1401, is amended by adding at the end  
21          the following new subparagraph:

22                  “(D) EXCEPTION FOR INDIVIDUAL RECEIV-  
23                  ING FREE CHOICE VOUCHERS.—The term ‘cov-  
24                  erage month’ shall not include any month in  
25                  which such individual has a free choice voucher

1 provided under section 10108 of the Patient  
2 Protection and Affordable Care Act.”.

3 (2) EFFECTIVE DATE.—The amendment made  
4 by this subsection shall apply to taxable years begin-  
5 ning after December 31, 2013.

6 (i) COORDINATION WITH EMPLOYER RESPONSIBIL-  
7 ITIES.—

8 (1) SHARED RESPONSIBILITY PENALTY.—

9 (A) IN GENERAL.—Subsection (c) of sec-  
10 tion 4980H of the Internal Revenue Code of  
11 1986, as added by section 1513, is amended by  
12 adding at the end the following new paragraph:

13 “(3) SPECIAL RULES FOR EMPLOYERS PRO-  
14 VIDING FREE CHOICE VOUCHERS.—No assessable  
15 payment shall be imposed under paragraph (1) for  
16 any month with respect to any employee to whom  
17 the employer provides a free choice voucher under  
18 section 10108 of the Patient Protection and Afford-  
19 able Care Act for such month.”.

20 (B) EFFECTIVE DATE.—The amendment  
21 made by this paragraph shall apply to months  
22 beginning after December 31, 2013.

23 (2) NOTIFICATION REQUIREMENT.—Section  
24 18B(a)(3) of the Fair Labor Standards Act of 1938,  
25 as added by section 1512, is amended—

1 (A) by inserting “and the employer does  
2 not offer a free choice voucher” after “Ex-  
3 change”; and

4 (B) by striking “will lose” and inserting  
5 “may lose”.

6 (j) EMPLOYER REPORTING.—

7 (1) IN GENERAL.—Subsection (a) of section  
8 6056 of the Internal Revenue Code of 1986, as  
9 added by section 1514, is amended by inserting  
10 “and every offering employer” before “shall”.

11 (2) OFFERING EMPLOYERS.—Subsection (f) of  
12 section 6056 of such Code, as added by section  
13 1514, is amended to read as follows:

14 “(f) DEFINITIONS.—For purposes of this section—

15 “(1) OFFERING EMPLOYER.—

16 “(A) IN GENERAL.—The term ‘offering  
17 employer’ means any offering employer (as de-  
18 fined in section 10108(b) of the Patient Protec-  
19 tion and Affordable Care Act) if the required  
20 contribution (within the meaning of section  
21 5000A(e)(1)(B)(i)) of any employee exceeds 8  
22 percent of the wages (as defined in section  
23 3121(a)) paid to such employee by such em-  
24 ployer.

1           “(B) INDEXING.—In the case of any cal-  
2           endar year beginning after 2014, the 8 percent  
3           under subparagraph (A) shall be adjusted for  
4           the calendar year to reflect the rate of premium  
5           growth between the preceding calendar year  
6           and 2013 over the rate of income growth for  
7           such period.

8           “(2) OTHER DEFINITIONS.—Any term used in  
9           this section which is also used in section 4980H  
10          shall have the meaning given such term by section  
11          4980H.”.

12          (3) CONFORMING AMENDMENTS.—

13                 (A) The heading of section 6056 of such  
14                 Code, as added by section 1514, is amended by  
15                 striking “**LARGE**” and inserting “**CERTAIN**”.

16                 (B) Section 6056(b)(2)(C) of such Code is  
17                 amended—

18                         (i) by inserting “in the case of an ap-  
19                         plicable large employer,” before “the  
20                         length” in clause (i);

21                         (ii) by striking “and” at the end of  
22                         clause (iii);

23                         (iii) by striking “applicable large em-  
24                         ployer” in clause (iv) and inserting “em-  
25                         ployer”;

1 (iv) by inserting “and” at the end of  
2 clause (iv); and

3 (v) by inserting at the end the fol-  
4 lowing new clause:

5 “(v) in the case of an offering em-  
6 ployer, the option for which the employer  
7 pays the largest portion of the cost of the  
8 plan and the portion of the cost paid by  
9 the employer in each of the enrollment cat-  
10 egories under such option,”.

11 (C) Section 6056(d)(2) of such Code is  
12 amended by inserting “or offering employer”  
13 after “applicable large employer”.

14 (D) Section 6056(e) of such Code is  
15 amended by inserting “or offering employer”  
16 after “applicable large employer”.

17 (E) Section 6724(d)(1)(B)(xxv) of such  
18 Code, as added by section 1514, is amended by  
19 striking “large” and inserting “certain”.

20 (F) Section 6724(d)(2)(HH) of such Code,  
21 as added by section 1514, is amended by strik-  
22 ing “large” and inserting “certain”.

23 (G) The table of sections for subpart D of  
24 part III of subchapter A of chapter 1 of such  
25 Code, as amended by section 1514, is amended

1 by striking “Large employers” in the item re-  
2 lating to section 6056 and inserting “Certain  
3 employers”.

4 (4) EFFECTIVE DATE.—The amendments made  
5 by this subsection shall apply to periods beginning  
6 after December 31, 2013.

7 **SEC. 10109. DEVELOPMENT OF STANDARDS FOR FINANCIAL**  
8 **AND ADMINISTRATIVE TRANSACTIONS.**

9 (a) ADDITIONAL TRANSACTION STANDARDS AND OP-  
10 ERATING RULES.—

11 (1) DEVELOPMENT OF ADDITIONAL TRANS-  
12 ACTION STANDARDS AND OPERATING RULES.—Sec-  
13 tion 1173(a) of the Social Security Act (42 U.S.C.  
14 1320d–2(a)), as amended by section 1104(b)(2), is  
15 amended—

16 (A) in paragraph (1)(B), by inserting be-  
17 fore the period the following: “, and subject to  
18 the requirements under paragraph (5)”; and

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

21 “(5) CONSIDERATION OF STANDARDIZATION OF  
22 ACTIVITIES AND ITEMS.—

23 “(A) IN GENERAL.—For purposes of car-  
24 rying out paragraph (1)(B), the Secretary shall  
25 solicit, not later than January 1, 2012, and not

1 less than every 3 years thereafter, input from  
2 entities described in subparagraph (B) on—

3 “(i) whether there could be greater  
4 uniformity in financial and administrative  
5 activities and items, as determined appro-  
6 priate by the Secretary; and

7 “(ii) whether such activities should be  
8 considered financial and administrative  
9 transactions (as described in paragraph  
10 (1)(B)) for which the adoption of stand-  
11 ards and operating rules would improve  
12 the operation of the health care system  
13 and reduce administrative costs.

14 “(B) SOLICITATION OF INPUT.—For pur-  
15 poses of subparagraph (A), the Secretary shall  
16 seek input from—

17 “(i) the National Committee on Vital  
18 and Health Statistics, the Health Informa-  
19 tion Technology Policy Committee, and the  
20 Health Information Technology Standards  
21 Committee; and

22 “(ii) standard setting organizations  
23 and stakeholders, as determined appro-  
24 priate by the Secretary.”.

1 (b) ACTIVITIES AND ITEMS FOR INITIAL CONSIDER-  
2 ATION.—For purposes of section 1173(a)(5) of the Social  
3 Security Act, as added by subsection (a), the Secretary  
4 of Health and Human Services (in this section referred  
5 to as the “Secretary”) shall, not later than January 1,  
6 2012, seek input on activities and items relating to the  
7 following areas:

8 (1) Whether the application process, including  
9 the use of a uniform application form, for enrollment  
10 of health care providers by health plans could be  
11 made electronic and standardized.

12 (2) Whether standards and operating rules de-  
13 scribed in section 1173 of the Social Security Act  
14 should apply to the health care transactions of auto-  
15 mobile insurance, worker’s compensation, and other  
16 programs or persons not described in section  
17 1172(a) of such Act (42 U.S.C. 1320d–1(a)).

18 (3) Whether standardized forms could apply to  
19 financial audits required by health plans, Federal  
20 and State agencies (including State auditors, the Of-  
21 fice of the Inspector General of the Department of  
22 Health and Human Services, and the Centers for  
23 Medicare & Medicaid Services), and other relevant  
24 entities as determined appropriate by the Secretary.

1           (4) Whether there could be greater trans-  
2           parency and consistency of methodologies and proc-  
3           esses used to establish claim edits used by health  
4           plans (as described in section 1171(5) of the Social  
5           Security Act (42 U.S.C. 1320d(5))).

6           (5) Whether health plans should be required to  
7           publish their timeliness of payment rules.

8           (c) ICD CODING CROSSWALKS.—

9           (1) ICD-9 TO ICD-10 CROSSWALK.—The Sec-  
10          retary shall task the ICD-9-CM Coordination and  
11          Maintenance Committee to convene a meeting, not  
12          later than January 1, 2011, to receive input from  
13          appropriate stakeholders (including health plans,  
14          health care providers, and clinicians) regarding the  
15          crosswalk between the Ninth and Tenth Revisions of  
16          the International Classification of Diseases (ICD-9  
17          and ICD-10, respectively) that is posted on the  
18          website of the Centers for Medicare & Medicaid  
19          Services, and make recommendations about appro-  
20          priate revisions to such crosswalk.

21          (2) REVISION OF CROSSWALK.—For purposes  
22          of the crosswalk described in paragraph (1), the Sec-  
23          retary shall make appropriate revisions and post any  
24          such revised crosswalk on the website of the Centers  
25          for Medicare & Medicaid Services.

1           (3) USE OF REVISED CROSSWALK.—For pur-  
2           poses of paragraph (2), any revised crosswalk shall  
3           be treated as a code set for which a standard has  
4           been adopted by the Secretary for purposes of sec-  
5           tion 1173(c)(1)(B) of the Social Security Act (42  
6           U.S.C. 1320d–2(c)(1)(B)).

7           (4) SUBSEQUENT CROSSWALKS.—For subse-  
8           quent revisions of the International Classification of  
9           Diseases that are adopted by the Secretary as a  
10          standard code set under section 1173(c) of the So-  
11          cial Security Act (42 U.S.C. 1320d–2(c)), the Sec-  
12          retary shall, after consultation with the appropriate  
13          stakeholders, post on the website of the Centers for  
14          Medicare & Medicaid Services a crosswalk between  
15          the previous and subsequent version of the Inter-  
16          national Classification of Diseases not later than the  
17          date of implementation of such subsequent revision.

## 18   **Subtitle B—Provisions Relating to** 19                                   **Title II**

### 20                           **PART I—MEDICAID AND CHIP**

#### 21   **SEC. 10201. AMENDMENTS TO THE SOCIAL SECURITY ACT** 22                                   **AND TITLE II OF THIS ACT.**

23          (a)(1) Section 1902(a)(10)(A)(i)(IX) of the Social  
24          Security Act (42 U.S.C. 1396a(a)(10)(A)(i)(IX)), as  
25          added by section 2004(a), is amended to read as follows:

1 “(IX) who—

2 “(aa) are under 26 years of  
3 age;

4 “(bb) are not described in or  
5 enrolled under any of subclauses  
6 (I) through (VII) of this clause  
7 or are described in any of such  
8 subclauses but have income that  
9 exceeds the level of income appli-  
10 cable under the State plan for  
11 eligibility to enroll for medical as-  
12 sistance under such subclause;

13 “(cc) were in foster care  
14 under the responsibility of the  
15 State on the date of attaining 18  
16 years of age or such higher age  
17 as the State has elected under  
18 section 475(8)(B)(iii); and

19 “(dd) were enrolled in the  
20 State plan under this title or  
21 under a waiver of the plan while  
22 in such foster care;”.

23 (2) Section 1902(a)(10) of the Social Security Act  
24 (42 U.S.C. 1396a(a)(10), as amended by section  
25 2001(a)(5)(A), is amended in the matter following sub-

1 paragraph (G), by striking “and (XV)” and inserting  
2 “(XV)”, and by inserting “and (XVI) if an individual is  
3 described in subclause (IX) of subparagraph (A)(i) and  
4 is also described in subclause (VIII) of that subparagraph,  
5 the medical assistance shall be made available to the indi-  
6 vidual through subclause (IX) instead of through sub-  
7 clause (VIII)” before the semicolon.

8 (3) Section 2004(d) of this Act is amended by strik-  
9 ing “2019” and inserting “2014”.

10 (b) Section 1902(k)(2) of the Social Security Act (42  
11 U.S.C. 1396a(k)(2)), as added by section 2001(a)(4)(A),  
12 is amended by striking “January 1, 2011” and inserting  
13 “April 1, 2010”.

14 (c) Section 1905 of the Social Security Act (42  
15 U.S.C. 1396d), as amended by sections 2001(a)(3),  
16 2001(a)(5)(C), 2006, and 4107(a)(2), is amended—

17 (1) in subsection (a), in the matter preceding  
18 paragraph (1), by inserting in clause (xiv), “or  
19 1902(a)(10)(A)(i)(IX)” before the comma;

20 (2) in subsection (b), in the first sentence, by  
21 inserting “, (z),” before “and (aa)”;

22 (3) in subsection (y)—

23 (A) in paragraph (1)(B)(ii)(II), in the first  
24 sentence, by inserting “includes inpatient hos-

1           pital services,” after “100 percent of the pov-  
2           erty line, that”; and

3                   (B) in paragraph (2)(A), by striking “on  
4           the date of enactment of the Patient Protection  
5           and Affordable Care Act” and inserting “as of  
6           December 1, 2009”;

7           (4) by inserting after subsection (y) the fol-  
8           lowing:

9           “(z) **EQUITABLE SUPPORT FOR CERTAIN STATES.—**

10                   “(1)(A) During the period that begins on Janu-  
11           ary 1, 2014, and ends on September 30, 2019, not-  
12           withstanding subsection (b), the Federal medical as-  
13           sistance percentage otherwise determined under sub-  
14           section (b) with respect to a fiscal year occurring  
15           during that period shall be increased by 2.2 percent-  
16           age points for any State described in subparagraph  
17           (B) for amounts expended for medical assistance for  
18           individuals who are not newly eligible (as defined in  
19           subsection (y)(2)) individuals described in subclause  
20           (VIII) of section 1902(a)(10)(A)(i).

21                   “(B) For purposes of subparagraph (A), a  
22           State described in this subparagraph is a State  
23           that—

24                           “(i) is an expansion State described in sub-  
25           section (y)(1)(B)(ii)(II);

1           “(ii) the Secretary determines will not re-  
2           ceive any payments under this title on the basis  
3           of an increased Federal medical assistance per-  
4           centage under subsection (y) for expenditures  
5           for medical assistance for newly eligible individ-  
6           uals (as so defined); and

7           “(iii) has not been approved by the Sec-  
8           retary to divert a portion of the DSH allotment  
9           for a State to the costs of providing medical as-  
10          sistance or other health benefits coverage under  
11          a waiver that is in effect on July 2009.

12          “(2)(A) During the period that begins on January  
13          1, 2014, and ends on December 31, 2016, notwithstanding  
14          subsection (b), the Federal medical assistance percentage  
15          otherwise determined under subsection (b) with respect to  
16          all or any portion of a fiscal year occurring during that  
17          period shall be increased by .5 percentage point for a State  
18          described in subparagraph (B) for amounts expended for  
19          medical assistance under the State plan under this title  
20          or under a waiver of that plan during that period.

21          “(B) For purposes of subparagraph (A), a State de-  
22          scribed in this subparagraph is a State that—

23                 “(i) is described in clauses (i) and (ii) of para-  
24                 graph (1)(B); and

1           “(ii) is the State with the highest percentage of  
2           its population insured during 2008, based on the  
3           Current Population Survey.

4           “(3) Notwithstanding subsection (b) and paragraphs  
5 (1) and (2) of this subsection, the Federal medical assist-  
6           ance percentage otherwise determined under subsection  
7 (b) with respect to all or any portion of a fiscal year that  
8 begins on or after January 1, 2017, for the State of Ne-  
9 braska, with respect to amounts expended for newly eligi-  
10 ble individuals described in subclause (VIII) of section  
11 1902(a)(10)(A)(i), shall be determined as provided for  
12 under subsection (y)(1)(A) (notwithstanding the period  
13 provided for in such paragraph).

14           “(4) The increase in the Federal medical assistance  
15 percentage for a State under paragraphs (1), (2), or (3)  
16 shall apply only for purposes of this title and shall not  
17 apply with respect to—

18           “(A) disproportionate share hospital payments  
19           described in section 1923;

20           “(B) payments under title IV;

21           “(C) payments under title XXI; and

22           “(D) payments under this title that are based  
23           on the enhanced FMAP described in section  
24           2105(b).”;

1           (5) in subsection (aa), is amended by striking  
2           “without regard to this subsection and subsection  
3           (y)” and inserting “without regard to this sub-  
4           section, subsection (y), subsection (z), and section  
5           10202 of the Patient Protection and Affordable Care  
6           Act” each place it appears;

7           (6) by adding after subsection (bb), the fol-  
8           lowing:

9           “(cc) REQUIREMENT FOR CERTAIN STATES.—Not-  
10          withstanding subsections (y), (z), and (aa), in the case of  
11          a State that requires political subdivisions within the State  
12          to contribute toward the non-Federal share of expendi-  
13          tures required under the State plan under section  
14          1902(a)(2), the State shall not be eligible for an increase  
15          in its Federal medical assistance percentage under such  
16          subsections if it requires that political subdivisions pay a  
17          greater percentage of the non-Federal share of such ex-  
18          penditures, or a greater percentage of the non-Federal  
19          share of payments under section 1923, than the respective  
20          percentages that would have been required by the State  
21          under the State plan under this title, State law, or both,  
22          as in effect on December 31, 2009, and without regard  
23          to any such increase. Voluntary contributions by a political  
24          subdivision to the non-Federal share of expenditures  
25          under the State plan under this title or to the non-Federal

1 share of payments under section 1923, shall not be consid-  
2 ered to be required contributions for purposes of this sub-  
3 section. The treatment of voluntary contributions, and the  
4 treatment of contributions required by a State under the  
5 State plan under this title, or State law, as provided by  
6 this subsection, shall also apply to the increases in the  
7 Federal medical assistance percentage under section 5001  
8 of the American Recovery and Reinvestment Act of  
9 2009.”.

10 (d) Section 1108(g)(4)(B) of the Social Security Act  
11 (42 U.S.C. 1308(g)(4)(B)), as added by section 2005(b),  
12 is amended by striking “income eligibility level in effect  
13 for that population under title XIX or under a waiver”  
14 and inserting “the highest income eligibility level in effect  
15 for parents under the commonwealth’s or territory’s State  
16 plan under title XIX or under a waiver of the plan”.

17 (e)(1) Section 1923(f) of the Social Security Act (42  
18 U.S.C. 1396r-4(f)), as amended by section 2551, is  
19 amended—

20 (A) in paragraph (6)—

21 (i) by striking the paragraph heading and  
22 inserting the following: “ALLOTMENT ADJUST-  
23 MENTS”; and

24 (ii) in subparagraph (B), by adding at the  
25 end the following:

## 101

1           “(iii) ALLOTMENT FOR 2D, 3RD, AND  
2           4TH QUARTER OF FISCAL YEAR 2012, FIS-  
3           CAL YEAR 2013, AND SUCCEEDING FISCAL  
4           YEARS.—Notwithstanding the table set  
5           forth in paragraph (2) or paragraph (7):

6                   “(I) 2D, 3RD, AND 4TH QUARTER  
7                   OF FISCAL YEAR 2012.—The DSH al-  
8                   lotment for Hawaii for the 2d, 3rd,  
9                   and 4th quarters of fiscal year 2012  
10                  shall be \$7,500,000.

11                   “(II) TREATMENT AS A LOW-DSH  
12                   STATE FOR FISCAL YEAR 2013 AND  
13                   SUCCEEDING FISCAL YEARS.—With  
14                   respect to fiscal year 2013, and each  
15                   fiscal year thereafter, the DSH allot-  
16                   ment for Hawaii shall be increased in  
17                   the same manner as allotments for  
18                   low DSH States are increased for  
19                   such fiscal year under clause (iii) of  
20                   paragraph (5)(B).

21                   “(III) CERTAIN HOSPITAL PAY-  
22                   MENTS.—The Secretary may not im-  
23                   pose a limitation on the total amount  
24                   of payments made to hospitals under  
25                   the QUEST section 1115 Demonstra-

1                   tion Project except to the extent that  
2                   such limitation is necessary to ensure  
3                   that a hospital does not receive pay-  
4                   ments in excess of the amounts de-  
5                   scribed in subsection (g), or as nec-  
6                   essary to ensure that such payments  
7                   under the waiver and such payments  
8                   pursuant to the allotment provided in  
9                   this clause do not, in the aggregate in  
10                  any year, exceed the amount that the  
11                  Secretary determines is equal to the  
12                  Federal medical assistance percentage  
13                  component attributable to dispropor-  
14                  tionate share hospital payment adjust-  
15                  ments for such year that is reflected  
16                  in the budget neutrality provision of  
17                  the QUEST Demonstration Project.”;  
18                  and

19                  (B) in paragraph (7)—

20                         (i) in subparagraph (A), in the matter pre-  
21                         ceding clause (i), by striking “subparagraph  
22                         (E)” and inserting “subparagraphs (E) and  
23                         (G)”;

24                         (ii) in subparagraph (B)—

1 (I) in clause (i), by striking sub-  
2 clauses (I) and (II), and inserting the fol-  
3 lowing:

4 “(I) if the State is a low DSH  
5 State described in paragraph (5)(B)  
6 and has spent not more than 99.90  
7 percent of the DSH allotments for the  
8 State on average for the period of fis-  
9 cal years 2004 through 2008, as of  
10 September 30, 2009, the applicable  
11 percentage is equal to 25 percent;

12 “(II) if the State is a low DSH  
13 State described in paragraph (5)(B)  
14 and has spent more than 99.90 per-  
15 cent of the DSH allotments for the  
16 State on average for the period of fis-  
17 cal years 2004 through 2008, as of  
18 September 30, 2009, the applicable  
19 percentage is equal to 17.5 percent;

20 “(III) if the State is not a low  
21 DSH State described in paragraph  
22 (5)(B) and has spent not more than  
23 99.90 percent of the DSH allotments  
24 for the State on average for the pe-  
25 riod of fiscal years 2004 through

1 2008, as of September 30, 2009, the  
2 applicable percentage is equal to 50  
3 percent; and

4 “(IV) if the State is not a low  
5 DSH State described in paragraph  
6 (5)(B) and has spent more than 99.90  
7 percent of the DSH allotments for the  
8 State on average for the period of fis-  
9 cal years 2004 through 2008, as of  
10 September 30, 2009, the applicable  
11 percentage is equal to 35 percent.”;

12 (II) in clause (ii), by striking sub-  
13 clauses (I) and (II), and inserting the fol-  
14 lowing:

15 “(I) if the State is a low DSH  
16 State described in paragraph (5)(B)  
17 and has spent not more than 99.90  
18 percent of the DSH allotments for the  
19 State on average for the period of fis-  
20 cal years 2004 through 2008, as of  
21 September 30, 2009, the applicable  
22 percentage is equal to the product of  
23 the percentage reduction in uncovered  
24 individuals for the fiscal year from the

1 preceding fiscal year and 27.5 per-  
2 cent;

3 “(II) if the State is a low DSH  
4 State described in paragraph (5)(B)  
5 and has spent more than 99.90 per-  
6 cent of the DSH allotments for the  
7 State on average for the period of fis-  
8 cal years 2004 through 2008, as of  
9 September 30, 2009, the applicable  
10 percentage is equal to the product of  
11 the percentage reduction in uncovered  
12 individuals for the fiscal year from the  
13 preceding fiscal year and 20 percent;

14 “(III) if the State is not a low  
15 DSH State described in paragraph  
16 (5)(B) and has spent not more than  
17 99.90 percent of the DSH allotments  
18 for the State on average for the pe-  
19 riod of fiscal years 2004 through  
20 2008, as of September 30, 2009, the  
21 applicable percentage is equal to the  
22 product of the percentage reduction in  
23 uncovered individuals for the fiscal  
24 year from the preceding fiscal year  
25 and 55 percent; and

1                   “(IV) if the State is not a low  
2                   DSH State described in paragraph  
3                   (5)(B) and has spent more than 99.90  
4                   percent of the DSH allotments for the  
5                   State on average for the period of fis-  
6                   cal years 2004 through 2008, as of  
7                   September 30, 2009, the applicable  
8                   percentage is equal to the product of  
9                   the percentage reduction in uncovered  
10                  individuals for the fiscal year from the  
11                  preceding fiscal year and 40 per-  
12                  cent.”;

13                  (III) in subparagraph (E), by striking  
14                  “35 percent” and inserting “50 percent”;  
15                  and

16                  (IV) by adding at the end the fol-  
17                  lowing:

18                  “(G) NONAPPLICATION.—The preceding  
19                  provisions of this paragraph shall not apply to  
20                  the DSH allotment determined for the State of  
21                  Hawaii for a fiscal year under paragraph (6).”.

22                  (f) Section 2551 of this Act is amended by striking  
23                  subsection (b).

24                  (g) Section 2105(d)(3)(B) of the Social Security Act  
25                  (42 U.S.C. 1397ee(d)(3)(B)), as added by section

1 2101(b)(1), is amended by adding at the end the following:  
2 “For purposes of eligibility for premium assistance for the  
3 purchase of a qualified health plan under section 36B of  
4 the Internal Revenue Code of 1986 and reduced cost-shar-  
5 ing under section 1402 of the Patient Protection and Af-  
6 fordable Care Act, children described in the preceding sen-  
7 tence shall be deemed to be ineligible for coverage under  
8 the State child health plan.”.

9 (h) Clause (i) of subparagraph (C) of section  
10 513(b)(2) of the Social Security Act, as added by section  
11 2953 of this Act, is amended to read as follows:

12 “(i) Healthy relationships, including  
13 marriage and family interactions.”.

14 (i) Section 1115 of the Social Security Act (42 U.S.C.  
15 1315) is amended by inserting after subsection (c) the fol-  
16 lowing:

17 “(d)(1) An application or renewal of any experi-  
18 mental, pilot, or demonstration project undertaken under  
19 subsection (a) to promote the objectives of title XIX or  
20 XXI in a State that would result in an impact on eligi-  
21 bility, enrollment, benefits, cost-sharing, or financing with  
22 respect to a State program under title XIX or XXI (in  
23 this subsection referred to as a ‘demonstration project’)  
24 shall be considered by the Secretary in accordance with

1 the regulations required to be promulgated under para-  
2 graph (2).

3 “(2) Not later than 180 days after the date of enact-  
4 ment of this subsection, the Secretary shall promulgate  
5 regulations relating to applications for, and renewals of,  
6 a demonstration project that provide for—

7 “(A) a process for public notice and comment  
8 at the State level, including public hearings, suffi-  
9 cient to ensure a meaningful level of public input;

10 “(B) requirements relating to—

11 “(i) the goals of the program to be imple-  
12 mented or renewed under the demonstration  
13 project;

14 “(ii) the expected State and Federal costs  
15 and coverage projections of the demonstration  
16 project; and

17 “(iii) the specific plans of the State to en-  
18 sure that the demonstration project will be in  
19 compliance with title XIX or XXI;

20 “(C) a process for providing public notice and  
21 comment after the application is received by the Sec-  
22 retary, that is sufficient to ensure a meaningful level  
23 of public input;

24 “(D) a process for the submission to the Sec-  
25 retary of periodic reports by the State concerning

1 the implementation of the demonstration project;  
2 and

3 “(E) a process for the periodic evaluation by  
4 the Secretary of the demonstration project.

5 “(3) The Secretary shall annually report to Congress  
6 concerning actions taken by the Secretary with respect to  
7 applications for demonstration projects under this sec-  
8 tion.”.

9 (j) Subtitle F of title III of this Act is amended by  
10 adding at the end the following:

11 **“SEC. 3512. GAO STUDY AND REPORT ON CAUSES OF AC-**  
12 **TION.**

13 “(a) STUDY.—

14 “(1) IN GENERAL.—The Comptroller General of  
15 the United States shall conduct a study of whether  
16 the development, recognition, or implementation of  
17 any guideline or other standards under a provision  
18 described in paragraph (2) would result in the estab-  
19 lishment of a new cause of action or claim.

20 “(2) PROVISIONS DESCRIBED.—The provisions  
21 described in this paragraph include the following:

22 “(A) Section 2701 (adult health quality  
23 measures).

24 “(B) Section 2702 (payment adjustments  
25 for health care acquired conditions).

1           “(C) Section 3001 (Hospital Value-Based  
2 Purchase Program).

3           “(D) Section 3002 (improvements to the  
4 Physician Quality Reporting Initiative).

5           “(E) Section 3003 (improvements to the  
6 Physician Feedback Program).

7           “(F) Section 3007 (value based payment  
8 modifier under physician fee schedule).

9           “(G) Section 3008 (payment adjustment  
10 for conditions acquired in hospitals).

11           “(H) Section 3013 (quality measure devel-  
12 opment).

13           “(I) Section 3014 (quality measurement).

14           “(J) Section 3021 (Establishment of Cen-  
15 ter for Medicare and Medicaid Innovation).

16           “(K) Section 3025 (hospital readmission  
17 reduction program).

18           “(L) Section 3501 (health care delivery  
19 system research, quality improvement).

20           “(M) Section 4003 (Task Force on Clinical  
21 and Preventive Services).

22           “(N) Section 4301 (research to optimize  
23 deliver of public health services).

24           “(b) REPORT.—Not later than 2 years after the date  
25 of enactment of this Act, the Comptroller General of the

1 United States shall submit to the appropriate committees  
2 of Congress, a report containing the findings made by the  
3 Comptroller General under the study under subsection  
4 (a).”.

5 **SEC. 10202. INCENTIVES FOR STATES TO OFFER HOME AND**  
6 **COMMUNITY-BASED SERVICES AS A LONG-**  
7 **TERM CARE ALTERNATIVE TO NURSING**  
8 **HOMES.**

9 (a) STATE BALANCING INCENTIVE PAYMENTS PRO-  
10 GRAM.—Notwithstanding section 1905(b) of the Social Se-  
11 curity Act (42 U.S.C. 1396d(b)), in the case of a bal-  
12 ancing incentive payment State, as defined in subsection  
13 (b), that meets the conditions described in subsection (c),  
14 during the balancing incentive period, the Federal medical  
15 assistance percentage determined for the State under sec-  
16 tion 1905(b) of such Act and, if applicable, increased  
17 under subsection (z) or (aa) shall be increased by the ap-  
18 plicable percentage points determined under subsection  
19 (d) with respect to eligible medical assistance expenditures  
20 described in subsection (e).

21 (b) BALANCING INCENTIVE PAYMENT STATE.—A  
22 balancing incentive payment State is a State—

23 (1) in which less than 50 percent of the total  
24 expenditures for medical assistance under the State  
25 Medicaid program for a fiscal year for long-term

1 services and supports (as defined by the Secretary  
2 under subsection (f)(1)) are for non-institutionally-  
3 based long-term services and supports described in  
4 subsection (f)(1)(B);

5 (2) that submits an application and meets the  
6 conditions described in subsection (c); and

7 (3) that is selected by the Secretary to partici-  
8 pate in the State balancing incentive payment pro-  
9 gram established under this section.

10 (c) CONDITIONS.—The conditions described in this  
11 subsection are the following:

12 (1) APPLICATION.—The State submits an appli-  
13 cation to the Secretary that includes, in addition to  
14 such other information as the Secretary shall re-  
15 quire—

16 (A) a proposed budget that details the  
17 State's plan to expand and diversify medical as-  
18 sistance for non-institutionally-based long-term  
19 services and supports described in subsection  
20 (f)(1)(B) under the State Medicaid program  
21 during the balancing incentive period and  
22 achieve the target spending percentage applica-  
23 ble to the State under paragraph (2), including  
24 through structural changes to how the State  
25 furnishes such assistance, such as through the

1 establishment of a “no wrong door - single  
2 entry point system”, optional presumptive eligi-  
3 bility, case management services, and the use of  
4 core standardized assessment instruments, and  
5 that includes a description of the new or ex-  
6 panded offerings of such services that the State  
7 will provide and the projected costs of such  
8 services; and

9 (B) in the case of a State that proposes to  
10 expand the provision of home and community-  
11 based services under its State Medicaid pro-  
12 gram through a State plan amendment under  
13 section 1915(i) of the Social Security Act, at  
14 the option of the State, an election to increase  
15 the income eligibility for such services from 150  
16 percent of the poverty line to such higher per-  
17 centage as the State may establish for such  
18 purpose, not to exceed 300 percent of the sup-  
19 plemental security income benefit rate estab-  
20 lished by section 1611(b)(1) of the Social Secu-  
21 rity Act (42 U.S.C. 1382(b)(1)).

22 (2) TARGET SPENDING PERCENTAGES.—

23 (A) In the case of a balancing incentive  
24 payment State in which less than 25 percent of  
25 the total expenditures for long-term services

1 and supports under the State Medicaid program  
2 for fiscal year 2009 are for home and commu-  
3 nity-based services, the target spending percent-  
4 age for the State to achieve by not later than  
5 October 1, 2015, is that 25 percent of the total  
6 expenditures for long-term services and sup-  
7 ports under the State Medicaid program are for  
8 home and community-based services.

9 (B) In the case of any other balancing in-  
10 centive payment State, the target spending per-  
11 centage for the State to achieve by not later  
12 than October 1, 2015, is that 50 percent of the  
13 total expenditures for long-term services and  
14 supports under the State Medicaid program are  
15 for home and community-based services.

16 (3) MAINTENANCE OF ELIGIBILITY REQUIRE-  
17 MENTS.—The State does not apply eligibility stand-  
18 ards, methodologies, or procedures for determining  
19 eligibility for medical assistance for non-institution-  
20 ally-based long-term services and supports described  
21 in subsection (f)(1)(B) under the State Medicaid  
22 program that are more restrictive than the eligibility  
23 standards, methodologies, or procedures in effect for  
24 such purposes on December 31, 2010.

1           (4) USE OF ADDITIONAL FUNDS.—The State  
2 agrees to use the additional Federal funds paid to  
3 the State as a result of this section only for pur-  
4 poses of providing new or expanded offerings of non-  
5 institutionally-based long-term services and supports  
6 described in subsection (f)(1)(B) under the State  
7 Medicaid program.

8           (5) STRUCTURAL CHANGES.—The State agrees  
9 to make, not later than the end of the 6-month pe-  
10 riod that begins on the date the State submits an  
11 application under this section, the following changes:

12           (A) “NO WRONG DOOR - SINGLE ENTRY  
13 POINT SYSTEM”.—Development of a statewide  
14 system to enable consumers to access all long-  
15 term services and supports through an agency,  
16 organization, coordinated network, or portal, in  
17 accordance with such standards as the State  
18 shall establish and that shall provide informa-  
19 tion regarding the availability of such services,  
20 how to apply for such services, referral services  
21 for services and supports otherwise available in  
22 the community, and determinations of financial  
23 and functional eligibility for such services and  
24 supports, or assistance with assessment proc-  
25 esses for financial and functional eligibility.

1 (B) CONFLICT-FREE CASE MANAGEMENT  
2 SERVICES.—Conflict-free case management  
3 services to develop a service plan, arrange for  
4 services and supports, support the beneficiary  
5 (and, if appropriate, the beneficiary’s care-  
6 givers) in directing the provision of services and  
7 supports for the beneficiary, and conduct ongo-  
8 ing monitoring to assure that services and sup-  
9 ports are delivered to meet the beneficiary’s  
10 needs and achieve intended outcomes.

11 (C) CORE STANDARDIZED ASSESSMENT IN-  
12 STRUMENTS.—Development of core standard-  
13 ized assessment instruments for determining  
14 eligibility for non-institutionally-based long-term  
15 services and supports described in subsection  
16 (f)(1)(B), which shall be used in a uniform  
17 manner throughout the State, to determine a  
18 beneficiary’s needs for training, support serv-  
19 ices, medical care, transportation, and other  
20 services, and develop an individual service plan  
21 to address such needs.

22 (6) DATA COLLECTION.—The State agrees to  
23 collect from providers of services and through such  
24 other means as the State determines appropriate the  
25 following data:

1 (A) SERVICES DATA.—Services data from  
2 providers of non-institutionally-based long-term  
3 services and supports described in subsection  
4 (f)(1)(B) on a per-beneficiary basis and in ac-  
5 cordance with such standardized coding proce-  
6 dures as the State shall establish in consulta-  
7 tion with the Secretary.

8 (B) QUALITY DATA.—Quality data on a se-  
9 lected set of core quality measures agreed upon  
10 by the Secretary and the State that are linked  
11 to population-specific outcomes measures and  
12 accessible to providers.

13 (C) OUTCOMES MEASURES.—Outcomes  
14 measures data on a selected set of core popu-  
15 lation-specific outcomes measures agreed upon  
16 by the Secretary and the State that are acces-  
17 sible to providers and include—

18 (i) measures of beneficiary and family  
19 caregiver experience with providers;

20 (ii) measures of beneficiary and family  
21 caregiver satisfaction with services; and

22 (iii) measures for achieving desired  
23 outcomes appropriate to a specific bene-  
24 ficiary, including employment, participa-

1                   tion in community life, health stability, and  
2                   prevention of loss in function.

3           (d) APPLICABLE PERCENTAGE POINTS INCREASE IN  
4 FMAP.—The applicable percentage points increase is—

5           (1) in the case of a balancing incentive payment  
6           State subject to the target spending percentage de-  
7           scribed in subsection (c)(2)(A), 5 percentage points;  
8           and

9           (2) in the case of any other balancing incentive  
10          payment State, 2 percentage points.

11          (e) ELIGIBLE MEDICAL ASSISTANCE EXPENDI-  
12          TURES.—

13           (1) IN GENERAL.—Subject to paragraph (2),  
14          medical assistance described in this subsection is  
15          medical assistance for non-institutionally-based long-  
16          term services and supports described in subsection  
17          (f)(1)(B) that is provided by a balancing incentive  
18          payment State under its State Medicaid program  
19          during the balancing incentive payment period.

20           (2) LIMITATION ON PAYMENTS.—In no case  
21          may the aggregate amount of payments made by the  
22          Secretary to balancing incentive payment States  
23          under this section during the balancing incentive pe-  
24          riod exceed \$3,000,000,000.

25          (f) DEFINITIONS.—In this section:

1           (1) LONG-TERM SERVICES AND SUPPORTS DE-  
2           FINED.—The term “long-term services and sup-  
3           ports” has the meaning given that term by Secretary  
4           and may include any of the following (as defined for  
5           purposes of State Medicaid programs):

6                   (A) INSTITUTIONALLY-BASED LONG-TERM  
7                   SERVICES AND SUPPORTS.—Services provided  
8                   in an institution, including the following:

9                           (i) Nursing facility services.

10                           (ii) Services in an intermediate care  
11                           facility for the mentally retarded described  
12                           in subsection (a)(15) of section 1905 of  
13                           such Act.

14                   (B) NON-INSTITUTIONALLY-BASED LONG-  
15                   TERM SERVICES AND SUPPORTS.—Services not  
16                   provided in an institution, including the fol-  
17                   lowing:

18                           (i) Home and community-based serv-  
19                           ices provided under subsection (c), (d), or  
20                           (i) of section 1915 of such Act or under a  
21                           waiver under section 1115 of such Act.

22                           (ii) Home health care services.

23                           (iii) Personal care services.

1 (iv) Services described in subsection  
2 (a)(26) of section 1905 of such Act (relat-  
3 ing to PACE program services).

4 (v) Self-directed personal assistance  
5 services described in section 1915(j) of  
6 such Act.

7 (2) BALANCING INCENTIVE PERIOD.—The term  
8 “balancing incentive period” means the period that  
9 begins on October 1, 2011, and ends on September  
10 30, 2015.

11 (3) POVERTY LINE.—The term “poverty line”  
12 has the meaning given that term in section  
13 2110(e)(5) of the Social Security Act (42 U.S.C.  
14 1397jj(c)(5)).

15 (4) STATE MEDICAID PROGRAM.—The term  
16 “State Medicaid program” means the State program  
17 for medical assistance provided under a State plan  
18 under title XIX of the Social Security Act and under  
19 any waiver approved with respect to such State plan.

20 **SEC. 10203. EXTENSION OF FUNDING FOR CHIP THROUGH**  
21 **FISCAL YEAR 2015 AND OTHER CHIP-RE-**  
22 **LATED PROVISIONS.**

23 (a) Section 1311(c)(1) of this Act is amended by  
24 striking “and” at the end of subparagraph (G), by striking

1 the period at the end of subparagraph (H) and inserting  
2 “; and”, and by adding at the end the following:

3 “(I) report to the Secretary at least annu-  
4 ally and in such manner as the Secretary shall  
5 require, pediatric quality reporting measures  
6 consistent with the pediatric quality reporting  
7 measures established under section 1139A of  
8 the Social Security Act.”.

9 (b) Effective as if included in the enactment of the  
10 Children’s Health Insurance Program Reauthorization  
11 Act of 2009 (Public Law 111–3):

12 (1) Section 1906(e)(2) of the Social Security  
13 Act (42 U.S.C. 1396e(e)(2)) is amended by striking  
14 “means” and all that follows through the period and  
15 inserting “has the meaning given that term in sec-  
16 tion 2105(c)(3)(A).”.

17 (2)(A) Section 1906A(a) of the Social Security  
18 Act (42 U.S.C. 1396e–1(a)), is amended by insert-  
19 ing before the period the following: “and the offering  
20 of such a subsidy is cost-effective, as defined for  
21 purposes of section 2105(c)(3)(A)”.

22 (B) This Act shall be applied without regard to  
23 subparagraph (A) of section 2003(a)(1) of this Act  
24 and that subparagraph and the amendment made by

1 that subparagraph are hereby deemed null, void, and  
2 of no effect.

3 (3) Section 2105(c)(10) of the Social Security  
4 Act (42 U.S.C. 1397ee(c)(10)) is amended—

5 (A) in subparagraph (A), in the first sen-  
6 tence, by inserting before the period the fol-  
7 lowing: “if the offering of such a subsidy is  
8 cost-effective, as defined for purposes of para-  
9 graph (3)(A)”;

10 (B) by striking subparagraph (M); and

11 (C) by redesignating subparagraph (N) as  
12 subparagraph (M).

13 (4) Section 2105(c)(3)(A) of the Social Security  
14 Act (42 U.S.C. 1397ee(c)(3)(A)) is amended—

15 (A) in the matter preceding clause (i), by  
16 striking “to” and inserting “to—”; and

17 (B) in clause (ii), by striking the period  
18 and inserting a semicolon.

19 (c) Section 2105 of the Social Security Act (42  
20 U.S.C. 1397ee), as amended by section 2101, is amend-  
21 ed—

22 (1) in subsection (b), in the second sentence, by  
23 striking “2013” and inserting “2015”; and

24 (2) in subsection (d)(3)—

25 (A) in subparagraph (A)—

1 (i) in the first sentence, by inserting  
2 “as a condition of receiving payments  
3 under section 1903(a),” after “2019,”;

4 (ii) in clause (i), by striking “or” at  
5 the end;

6 (iii) by redesignating clause (ii) as  
7 clause (iii); and

8 (iv) by inserting after clause (i), the  
9 following:

10 “(ii) after September 30, 2015, enroll-  
11 ing children eligible to be targeted low-in-  
12 come children under the State child health  
13 plan in a qualified health plan that has  
14 been certified by the Secretary under sub-  
15 paragraph (C); or”;

16 (B) in subparagraph (B), by striking “pro-  
17 vided coverage” and inserting “screened for eli-  
18 gibility for medical assistance under the State  
19 plan under title XIX or a waiver of that plan  
20 and, if found eligible, enrolled in such plan or  
21 a waiver. In the case of such children who, as  
22 a result of such screening, are determined to  
23 not be eligible for medical assistance under the  
24 State plan or a waiver under title XIX, the  
25 State shall establish procedures to ensure that

1 the children are enrolled in a qualified health  
2 plan that has been certified by the Secretary  
3 under subparagraph (C) and is offered”; and

4 (C) by adding at the end the following:

5 “(C) CERTIFICATION OF COMPARABILITY  
6 OF PEDIATRIC COVERAGE OFFERED BY QUALI-  
7 FIED HEALTH PLANS.—With respect to each  
8 State, the Secretary, not later than April 1,  
9 2015, shall review the benefits offered for chil-  
10 dren and the cost-sharing imposed with respect  
11 to such benefits by qualified health plans of-  
12 fered through an Exchange established by the  
13 State under section 1311 of the Patient Protec-  
14 tion and Affordable Care Act and shall certify  
15 those plans that offer benefits for children and  
16 impose cost-sharing with respect to such bene-  
17 fits that the Secretary determines are at least  
18 comparable to the benefits offered and cost-  
19 sharing protections provided under the State  
20 child health plan.”.

21 (d)(1) Section 2104(a) of such Act (42 U.S.C.  
22 1397dd(a)) is amended—

23 (A) in paragraph (15), by striking “and” at the  
24 end; and

1 (B) by striking paragraph (16) and inserting  
2 the following:

3 “(16) for fiscal year 2013, \$17,406,000,000;

4 “(17) for fiscal year 2014, \$19,147,000,000;

5 and

6 “(18) for fiscal year 2015, for purposes of mak-  
7 ing 2 semi-annual allotments—

8 (A) \$2,850,000,000 for the period begin-  
9 ning on October 1, 2014, and ending on March  
10 31, 2015, and

11 (B) \$2,850,000,000 for the period begin-  
12 ning on April 1, 2015, and ending on Sep-  
13 tember 30, 2015.”.

14 (2)(A) Section 2104(m) of such Act (42 U.S.C.  
15 1397dd(m)), as amended by section 2102(a)(1), is amend-  
16 ed—

17 (i) in the subsection heading, by striking  
18 “2013” and inserting “2015”;

19 (ii) in paragraph (2)—

20 (I) in the paragraph heading, by striking  
21 “2012” and inserting “2014”; and

22 (II) by adding at the end the following:

23 “(B) FISCAL YEARS 2013 AND 2014.—Sub-  
24 ject to paragraphs (4) and (6), from the  
25 amount made available under paragraphs (16)

1 and (17) of subsection (a) for fiscal years 2013  
2 and 2014, respectively, the Secretary shall com-  
3 pute a State allotment for each State (including  
4 the District of Columbia and each common-  
5 wealth and territory) for each such fiscal year  
6 as follows:

7 “(i) REBASING IN FISCAL YEAR  
8 2013.—For fiscal year 2013, the allotment  
9 of the State is equal to the Federal pay-  
10 ments to the State that are attributable to  
11 (and countable towards) the total amount  
12 of allotments available under this section  
13 to the State in fiscal year 2012 (including  
14 payments made to the State under sub-  
15 section (n) for fiscal year 2012 as well as  
16 amounts redistributed to the State in fiscal  
17 year 2012), multiplied by the allotment in-  
18 crease factor under paragraph (5) for fis-  
19 cal year 2013.

20 “(ii) GROWTH FACTOR UPDATE FOR  
21 FISCAL YEAR 2014.—For fiscal year 2014,  
22 the allotment of the State is equal to the  
23 sum of—

1                   “(I) the amount of the State al-  
2                   lotment under clause (i) for fiscal year  
3                   2013; and

4                   “(II) the amount of any pay-  
5                   ments made to the State under sub-  
6                   section (n) for fiscal year 2013,

7                   multiplied by the allotment increase factor  
8                   under paragraph (5) for fiscal year 2014.”;  
9                   (iii) in paragraph (3)—

10                   (I) in the paragraph heading, by strik-  
11                   ing “2013” and inserting “2015”;

12                   (II) in subparagraphs (A) and (B), by  
13                   striking “paragraph (16)” each place it ap-  
14                   pears and inserting “paragraph (18)”;

15                   (III) in subparagraph (C)—

16                   (aa) by striking “2012” each  
17                   place it appears and inserting “2014”;  
18                   and

19                   (bb) by striking “2013” and in-  
20                   serting “2015”; and

21                   (IV) in subparagraph (D)—

22                   (aa) in clause (i)(I), by striking  
23                   “subsection (a)(16)(A)” and inserting  
24                   “subsection (a)(18)(A)”; and

1 (bb) in clause (ii)(II), by striking  
2 “subsection (a)(16)(B)” and inserting  
3 “subsection (a)(18)(B)”;  
4 (iv) in paragraph (4), by striking “2013”  
5 and inserting “2015”;  
6 (v) in paragraph (6)—  
7 (I) in subparagraph (A), by striking  
8 “2013” and inserting “2015”; and  
9 (II) in the flush language after and  
10 below subparagraph (B)(ii), by striking “or  
11 fiscal year 2012” and inserting “, fiscal  
12 year 2012, or fiscal year 2014”; and  
13 (vi) in paragraph (8)—  
14 (I) in the paragraph heading, by strik-  
15 ing “2013” and inserting “2015”; and  
16 (II) by striking “2013” and inserting  
17 “2015”.  
18 (B) Section 2104(n) of such Act (42 U.S.C.  
19 1397dd(n)) is amended—  
20 (i) in paragraph (2)—  
21 (I) in subparagraph (A)(ii)—  
22 (aa) by striking “2012” and inserting  
23 “2014”; and  
24 (bb) by striking “2013” and inserting  
25 “2015”;

1 (II) in subparagraph (B)—

2 (aa) by striking “2012” and inserting  
3 “2014”; and

4 (bb) by striking “2013” and inserting  
5 “2015”; and

6 (ii) in paragraph (3)(A), by striking “or a semi-  
7 annual allotment period for fiscal year 2013” and  
8 inserting “fiscal year 2013, fiscal year 2014, or a  
9 semi-annual allotment period for fiscal year 2015”.

10 (C) Section 2105(g)(4) of such Act (42 U.S.C.  
11 1397ee(g)(4)) is amended—

12 (i) in the paragraph heading, by striking “2013”  
13 and inserting “2015”; and

14 (ii) in subparagraph (A), by striking “2013”  
15 and inserting “2015”.

16 (D) Section 2110(b) of such Act (42 U.S.C.  
17 1397jj(b)) is amended—

18 (i) in paragraph (2)(B), by inserting “except as  
19 provided in paragraph (6),” before “a child”; and

20 (ii) by adding at the end the following new  
21 paragraph:

22 “(6) EXCEPTIONS TO EXCLUSION OF CHILDREN  
23 OF EMPLOYEES OF A PUBLIC AGENCY IN THE  
24 STATE.—

1           “(A) IN GENERAL.—A child shall not be  
2 considered to be described in paragraph (2)(B)  
3 if—

4                   “(i) the public agency that employs a  
5 member of the child’s family to which such  
6 paragraph applies satisfies subparagraph  
7 (B); or

8                   “(ii) subparagraph (C) applies to such  
9 child.

10           “(B) MAINTENANCE OF EFFORT WITH RE-  
11 SPECT TO PER PERSON AGENCY CONTRIBUTION  
12 FOR FAMILY COVERAGE.—For purposes of sub-  
13 paragraph (A)(i), a public agency satisfies this  
14 subparagraph if the amount of annual agency  
15 expenditures made on behalf of each employee  
16 enrolled in health coverage paid for by the  
17 agency that includes dependent coverage for the  
18 most recent State fiscal year is not less than  
19 the amount of such expenditures made by the  
20 agency for the 1997 State fiscal year, increased  
21 by the percentage increase in the medical care  
22 expenditure category of the Consumer Price  
23 Index for All-Urban Consumers (all items: U.S.  
24 City Average) for such preceding fiscal year.

1           “(C) HARDSHIP EXCEPTION.—For pur-  
2           poses of subparagraph (A)(ii), this subpara-  
3           graph applies to a child if the State determines,  
4           on a case-by-case basis, that the annual aggre-  
5           gate amount of premiums and cost-sharing im-  
6           posed for coverage of the family of the child  
7           would exceed 5 percent of such family’s income  
8           for the year involved.”.

9           (E) Section 2113 of such Act (42 U.S.C. 1397mm)  
10          is amended—

11           (i) in subsection (a)(1), by striking “2013” and  
12          inserting “2015”; and

13           (ii) in subsection (g), by striking  
14          “\$100,000,000 for the period of fiscal years 2009  
15          through 2013” and inserting “\$140,000,000 for the  
16          period of fiscal years 2009 through 2015”.

17          (F) Section 108 of Public Law 111–3 is amended by  
18          striking “\$11,706,000,000” and all that follows through  
19          the second sentence and inserting “\$15,361,000,000 to  
20          accompany the allotment made for the period beginning  
21          on October 1, 2014, and ending on March 31, 2015, under  
22          section 2104(a)(18)(A) of the Social Security Act (42  
23          U.S.C. 1397dd(a)(18)(A)), to remain available until ex-  
24          pended. Such amount shall be used to provide allotments  
25          to States under paragraph (3) of section 2104(m) of the

1 Social Security Act (42 U.S.C. 1397dd(m)) for the first  
2 6 months of fiscal year 2015 in the same manner as allot-  
3 ments are provided under subsection (a)(18)(A) of such  
4 section 2104 and subject to the same terms and conditions  
5 as apply to the allotments provided from such subsection  
6 (a)(18)(A).”.

7 **PART II—SUPPORT FOR PREGNANT AND**  
8 **PARENTING TEENS AND WOMEN**

9 **SEC. 10211. DEFINITIONS.**

10 In this part:

11 (1) **ACCOMPANIMENT.**—The term “accompani-  
12 ment” means assisting, representing, and accom-  
13 panying a woman in seeking judicial relief for child  
14 support, child custody, restraining orders, and res-  
15 titution for harm to persons and property, and in fil-  
16 ing criminal charges, and may include the payment  
17 of court costs and reasonable attorney and witness  
18 fees associated therewith.

19 (2) **ELIGIBLE INSTITUTION OF HIGHER EDU-**  
20 **CATION.**—The term “eligible institution of higher  
21 education” means an institution of higher education  
22 (as such term is defined in section 101 of the High-  
23 er Education Act of 1965 (20 U.S.C. 1001)) that  
24 has established and operates, or agrees to establish  
25 and operate upon the receipt of a grant under this

1 part, a pregnant and parenting student services of-  
2 fice.

3 (3) COMMUNITY SERVICE CENTER.—The term  
4 “community service center” means a non-profit or-  
5 ganization that provides social services to residents  
6 of a specific geographical area via direct service or  
7 by contract with a local governmental agency.

8 (4) HIGH SCHOOL.—The term “high school”  
9 means any public or private school that operates  
10 grades 10 through 12, inclusive, grades 9 through  
11 12, inclusive or grades 7 through 12, inclusive.

12 (5) INTERVENTION SERVICES.—The term  
13 “intervention services” means, with respect to do-  
14 mestic violence, sexual violence, sexual assault, or  
15 stalking, 24-hour telephone hotline services for police  
16 protection and referral to shelters.

17 (6) SECRETARY.—The term “Secretary” means  
18 the Secretary of Health and Human Services.

19 (7) STATE.—The term “State” includes the  
20 District of Columbia, any commonwealth, possession,  
21 or other territory of the United States, and any In-  
22 dian tribe or reservation.

23 (8) SUPPORTIVE SOCIAL SERVICES.—The term  
24 “supportive social services” means transitional and  
25 permanent housing, vocational counseling, and indi-

1       vidual and group counseling aimed at preventing do-  
2       mestic violence, sexual violence, sexual assault, or  
3       stalking.

4               (9) VIOLENCE.—The term “violence” means ac-  
5       tual violence and the risk or threat of violence.

6       **SEC. 10212. ESTABLISHMENT OF PREGNANCY ASSISTANCE**  
7                               **FUND.**

8       (a) IN GENERAL.—The Secretary, in collaboration  
9       and coordination with the Secretary of Education (as ap-  
10      propriate), shall establish a Pregnancy Assistance Fund  
11      to be administered by the Secretary, for the purpose of  
12      awarding competitive grants to States to assist pregnant  
13      and parenting teens and women.

14      (b) USE OF FUND.—A State may apply for a grant  
15      under subsection (a) to carry out any activities provided  
16      for in section 10213.

17      (c) APPLICATIONS.—To be eligible to receive a grant  
18      under subsection (a), a State shall submit to the Secretary  
19      an application at such time, in such manner, and con-  
20      taining such information as the Secretary may require, in-  
21      cluding a description of the purposes for which the grant  
22      is being requested and the designation of a State agency  
23      for receipt and administration of funding received under  
24      this part.

1 **SEC. 10213. PERMISSIBLE USES OF FUND.**

2 (a) IN GENERAL.—A State shall use amounts re-  
3 ceived under a grant under section 10212 for the purposes  
4 described in this section to assist pregnant and parenting  
5 teens and women.

6 (b) INSTITUTIONS OF HIGHER EDUCATION.—

7 (1) IN GENERAL.—A State may use amounts  
8 received under a grant under section 10212 to make  
9 funding available to eligible institutions of higher  
10 education to enable the eligible institutions to estab-  
11 lish, maintain, or operate pregnant and parenting  
12 student services. Such funding shall be used to sup-  
13 plement, not supplant, existing funding for such  
14 services.

15 (2) APPLICATION.—An eligible institution of  
16 higher education that desires to receive funding  
17 under this subsection shall submit an application to  
18 the designated State agency at such time, in such  
19 manner, and containing such information as the  
20 State agency may require.

21 (3) MATCHING REQUIREMENT.—An eligible in-  
22 stitution of higher education that receives funding  
23 under this subsection shall contribute to the conduct  
24 of the pregnant and parenting student services office  
25 supported by the funding an amount from non-Fed-  
26 eral funds equal to 25 percent of the amount of the

1 funding provided. The non-Federal share may be in  
2 cash or in-kind, fairly evaluated, including services,  
3 facilities, supplies, or equipment.

4 (4) USE OF FUNDS FOR ASSISTING PREGNANT  
5 AND PARENTING COLLEGE STUDENTS.—An eligible  
6 institution of higher education that receives funding  
7 under this subsection shall use such funds to estab-  
8 lish, maintain or operate pregnant and parenting  
9 student services and may use such funding for the  
10 following programs and activities:

11 (A) Conduct a needs assessment on cam-  
12 pus and within the local community—

13 (i) to assess pregnancy and parenting  
14 resources, located on the campus or within  
15 the local community, that are available to  
16 meet the needs described in subparagraph  
17 (B); and

18 (ii) to set goals for—

19 (I) improving such resources for  
20 pregnant, parenting, and prospective  
21 parenting students; and

22 (II) improving access to such re-  
23 sources.

24 (B) Annually assess the performance of  
25 the eligible institution in meeting the following

1 needs of students enrolled in the eligible institu-  
2 tion who are pregnant or are parents:

3 (i) The inclusion of maternity cov-  
4 erage and the availability of riders for ad-  
5 ditional family members in student health  
6 care.

7 (ii) Family housing.

8 (iii) Child care.

9 (iv) Flexible or alternative academic  
10 scheduling, such as telecommuting pro-  
11 grams, to enable pregnant or parenting  
12 students to continue their education or  
13 stay in school.

14 (v) Education to improve parenting  
15 skills for mothers and fathers and to  
16 strengthen marriages.

17 (vi) Maternity and baby clothing, baby  
18 food (including formula), baby furniture,  
19 and similar items to assist parents and  
20 prospective parents in meeting the material  
21 needs of their children.

22 (vii) Post-partum counseling.

23 (C) Identify public and private service pro-  
24 viders, located on the campus of the eligible in-  
25 stitution or within the local community, that

1 are qualified to meet the needs described in  
2 subparagraph (B), and establishes programs  
3 with qualified providers to meet such needs.

4 (D) Assist pregnant and parenting stu-  
5 dents, fathers or spouses in locating and obtain-  
6 ing services that meet the needs described in  
7 subparagraph (B).

8 (E) If appropriate, provide referrals for  
9 prenatal care and delivery, infant or foster care,  
10 or adoption, to a student who requests such in-  
11 formation. An office shall make such referrals  
12 only to service providers that serve the following  
13 types of individuals:

14 (i) Parents.

15 (ii) Prospective parents awaiting  
16 adoption.

17 (iii) Women who are pregnant and  
18 plan on parenting or placing the child for  
19 adoption.

20 (iv) Parenting or prospective par-  
21 enting couples.

22 (5) REPORTING.—

23 (A) ANNUAL REPORT BY INSTITUTIONS.—

24 (i) IN GENERAL.—For each fiscal year  
25 that an eligible institution of higher edu-

1 cation receives funds under this subsection,  
2 the eligible institution shall prepare and  
3 submit to the State, by the date deter-  
4 mined by the State, a report that—

5 (I) itemizes the pregnant and  
6 parenting student services office's ex-  
7 penditures for the fiscal year;

8 (II) contains a review and evalua-  
9 tion of the performance of the office  
10 in fulfilling the requirements of this  
11 section, using the specific performance  
12 criteria or standards established  
13 under subparagraph (B)(i); and

14 (III) describes the achievement of  
15 the office in meeting the needs listed  
16 in paragraph (4)(B) of the students  
17 served by the eligible institution, and  
18 the frequency of use of the office by  
19 such students.

20 (ii) PERFORMANCE CRITERIA.—Not  
21 later than 180 days before the date the an-  
22 nual report described in clause (i) is sub-  
23 mitted, the State—

24 (I) shall identify the specific per-  
25 formance criteria or standards that

1 shall be used to prepare the report;  
2 and

3 (II) may establish the form or  
4 format of the report.

5 (B) REPORT BY STATE.—The State shall  
6 annually prepare and submit a report on the  
7 findings under this subsection, including the  
8 number of eligible institutions of higher edu-  
9 cation that were awarded funds and the number  
10 of students served by each pregnant and par-  
11 enting student services office receiving funds  
12 under this section, to the Secretary.

13 (c) SUPPORT FOR PREGNANT AND PARENTING  
14 TEENS.—A State may use amounts received under a  
15 grant under section 10212 to make funding available to  
16 eligible high schools and community service centers to es-  
17 tablish, maintain or operate pregnant and parenting serv-  
18 ices in the same general manner and in accordance with  
19 all conditions and requirements described in subsection  
20 (b), except that paragraph (3) of such subsection shall not  
21 apply for purposes of this subsection.

22 (d) IMPROVING SERVICES FOR PREGNANT WOMEN  
23 WHO ARE VICTIMS OF DOMESTIC VIOLENCE, SEXUAL VI-  
24 OLENCE, SEXUAL ASSAULT, AND STALKING.—

1           (1) IN GENERAL.—A State may use amounts  
2 received under a grant under section 10212 to make  
3 funding available to its State Attorney General to  
4 assist Statewide offices in providing—

5           (A) intervention services, accompaniment,  
6 and supportive social services for eligible preg-  
7 nant women who are victims of domestic vio-  
8 lence, sexual violence, sexual assault, or stalk-  
9 ing.

10           (B) technical assistance and training (as  
11 described in subsection (c)) relating to violence  
12 against eligible pregnant women to be made  
13 available to the following:

14           (i) Federal, State, tribal, territorial,  
15 and local governments, law enforcement  
16 agencies, and courts.

17           (ii) Professionals working in legal, so-  
18 cial service, and health care settings.

19           (iii) Nonprofit organizations.

20           (iv) Faith-based organizations.

21           (2) ELIGIBILITY.—To be eligible for a grant  
22 under paragraph (1), a State Attorney General shall  
23 submit an application to the designated State agency  
24 at such time, in such manner, and containing such  
25 information, as specified by the State.

1           (3) TECHNICAL ASSISTANCE AND TRAINING DE-  
2           SCRIBED.—For purposes of paragraph (1)(B), tech-  
3           nical assistance and training is—

4                   (A) the identification of eligible pregnant  
5                   women experiencing domestic violence, sexual  
6                   violence, sexual assault, or stalking;

7                   (B) the assessment of the immediate and  
8                   short-term safety of such a pregnant woman,  
9                   the evaluation of the impact of the violence or  
10                  stalking on the pregnant woman’s health, and  
11                  the assistance of the pregnant woman in devel-  
12                  oping a plan aimed at preventing further do-  
13                  mestic violence, sexual violence, sexual assault,  
14                  or stalking, as appropriate;

15                  (C) the maintenance of complete medical  
16                  or forensic records that include the documenta-  
17                  tion of any examination, treatment given, and  
18                  referrals made, recording the location and na-  
19                  ture of the pregnant woman’s injuries, and the  
20                  establishment of mechanisms to ensure the pri-  
21                  vacy and confidentiality of those medical  
22                  records; and

23                  (D) the identification and referral of the  
24                  pregnant woman to appropriate public and pri-  
25                  vate nonprofit entities that provide intervention

1 services, accompaniment, and supportive social  
2 services.

3 (4) **ELIGIBLE PREGNANT WOMAN.**—In this sub-  
4 section, the term “eligible pregnant woman” means  
5 any woman who is pregnant on the date on which  
6 such woman becomes a victim of domestic violence,  
7 sexual violence, sexual assault, or stalking or who  
8 was pregnant during the one-year period before such  
9 date.

10 (e) **PUBLIC AWARENESS AND EDUCATION.**—A State  
11 may use amounts received under a grant under section  
12 10212 to make funding available to increase public aware-  
13 ness and education concerning any services available to  
14 pregnant and parenting teens and women under this part,  
15 or any other resources available to pregnant and parenting  
16 women in keeping with the intent and purposes of this  
17 part. The State shall be responsible for setting guidelines  
18 or limits as to how much of funding may be utilized for  
19 public awareness and education in any funding award.

20 **SEC. 10214. APPROPRIATIONS.**

21 There is authorized to be appropriated, and there are  
22 appropriated, \$25,000,000 for each of fiscal years 2010  
23 through 2019, to carry out this part.

1 **PART III—INDIAN HEALTH CARE IMPROVEMENT**

2 **SEC. 10221. INDIAN HEALTH CARE IMPROVEMENT.**

3 (a) IN GENERAL.—Except as provided in subsection  
4 (b), S. 1790 entitled “A bill to amend the Indian Health  
5 Care Improvement Act to revise and extend that Act, and  
6 for other purposes.”, as reported by the Committee on In-  
7 dian Affairs of the Senate in December 2009, is enacted  
8 into law.

9 (b) AMENDMENTS.—

10 (1) Section 119 of the Indian Health Care Im-  
11 provement Act (as amended by section 111 of the  
12 bill referred to in subsection (a)) is amended—

13 (A) in subsection (d)—

14 (i) in paragraph (2), by striking “In  
15 establishing” and inserting “Subject to  
16 paragraphs (3) and (4), in establishing”;  
17 and

18 (ii) by adding at the end the fol-  
19 lowing:

20 “(3) ELECTION OF INDIAN TRIBE OR TRIBAL  
21 ORGANIZATION.—

22 “(A) IN GENERAL.—Subparagraph (B) of  
23 paragraph (2) shall not apply in the case of an  
24 election made by an Indian tribe or tribal orga-  
25 nization located in a State (other than Alaska)  
26 in which the use of dental health aide therapist

1 services or midlevel dental health provider serv-  
2 ices is authorized under State law to supply  
3 such services in accordance with State law.

4 “(B) ACTION BY SECRETARY.—On an elec-  
5 tion by an Indian tribe or tribal organization  
6 under subparagraph (A), the Secretary, acting  
7 through the Service, shall facilitate implementa-  
8 tion of the services elected.

9 “(4) VACANCIES.—The Secretary shall not fill  
10 any vacancy for a certified dentist in a program op-  
11 erated by the Service with a dental health aide ther-  
12 apist.”; and

13 (B) by adding at the end the following:

14 “(e) EFFECT OF SECTION.—Nothing in this section  
15 shall restrict the ability of the Service, an Indian tribe,  
16 or a tribal organization to participate in any program or  
17 to provide any service authorized by any other Federal  
18 law.”.

19 (2) The Indian Health Care Improvement Act  
20 (as amended by section 134(b) of the bill referred to  
21 in subsection (a)) is amended by striking section 125  
22 (relating to treatment of scholarships for certain  
23 purposes).

24 (3) Section 806 of the Indian Health Care Im-  
25 provement Act (25 U.S.C. 1676) is amended—

1 (A) by striking “Any limitation” and in-  
2 serting the following:

3 “(a) HHS APPROPRIATIONS.—Any limitation”; and

4 (B) by adding at the end the following:

5 “(b) LIMITATIONS PURSUANT TO OTHER FEDERAL  
6 LAW.—Any limitation pursuant to other Federal laws on  
7 the use of Federal funds appropriated to the Service shall  
8 apply with respect to the performance or coverage of abor-  
9 tions.”.

10 (4) The bill referred to in subsection (a) is  
11 amended by striking section 201.

12 **Subtitle C—Provisions Relating to**  
13 **Title III**

14 **SEC. 10301. PLANS FOR A VALUE-BASED PURCHASING PRO-**  
15 **GRAM FOR AMBULATORY SURGICAL CEN-**  
16 **TERS.**

17 (a) IN GENERAL.—Section 3006 is amended by add-  
18 ing at the end the following new subsection:

19 “(f) AMBULATORY SURGICAL CENTERS.—

20 “(1) IN GENERAL.—The Secretary shall develop  
21 a plan to implement a value-based purchasing pro-  
22 gram for payments under the Medicare program  
23 under title XVIII of the Social Security Act for am-  
24 bulatory surgical centers (as described in section

1 1833(i) of the Social Security Act (42 U.S.C.  
2 1395l(i)).

3 “(2) DETAILS.—In developing the plan under  
4 paragraph (1), the Secretary shall consider the fol-  
5 lowing issues:

6 “(A) The ongoing development, selection,  
7 and modification process for measures (includ-  
8 ing under section 1890 of the Social Security  
9 Act (42 U.S.C. 1395aaa) and section 1890A of  
10 such Act, as added by section 3014), to the ex-  
11 tent feasible and practicable, of all dimensions  
12 of quality and efficiency in ambulatory surgical  
13 centers.

14 “(B) The reporting, collection, and valida-  
15 tion of quality data.

16 “(C) The structure of value-based payment  
17 adjustments, including the determination of  
18 thresholds or improvements in quality that  
19 would substantiate a payment adjustment, the  
20 size of such payments, and the sources of fund-  
21 ing for the value-based bonus payments.

22 “(D) Methods for the public disclosure of  
23 information on the performance of ambulatory  
24 surgical centers.



1 **SEC. 10303. DEVELOPMENT OF OUTCOME MEASURES.**

2 (a) DEVELOPMENT.—Section 931 of the Public  
3 Health Service Act, as added by section 3013(a), is  
4 amended by adding at the end the following new sub-  
5 section:

6 “(f) DEVELOPMENT OF OUTCOME MEASURES.—

7 “(1) IN GENERAL.—The Secretary shall de-  
8 velop, and periodically update (not less than every 3  
9 years), provider-level outcome measures for hospitals  
10 and physicians, as well as other providers as deter-  
11 mined appropriate by the Secretary.

12 “(2) CATEGORIES OF MEASURES.—The meas-  
13 ures developed under this subsection shall include, to  
14 the extent determined appropriate by the Sec-  
15 retary—

16 “(A) outcome measurement for acute and  
17 chronic diseases, including, to the extent fea-  
18 sible, the 5 most prevalent and resource-inten-  
19 sive acute and chronic medical conditions; and

20 “(B) outcome measurement for primary  
21 and preventative care, including, to the extent  
22 feasible, measurements that cover provision of  
23 such care for distinct patient populations (such  
24 as healthy children, chronically ill adults, or in-  
25 firm elderly individuals).

1           “(3) GOALS.—In developing such measures, the  
2       Secretary shall seek to—

3           “(A) address issues regarding risk adjust-  
4       ment, accountability, and sample size;

5           “(B) include the full scope of services that  
6       comprise a cycle of care; and

7           “(C) include multiple dimensions.

8       “(4) TIMEFRAME.—

9           “(A) ACUTE AND CHRONIC DISEASES.—  
10       Not later than 24 months after the date of en-  
11       actment of this Act, the Secretary shall develop  
12       not less than 10 measures described in para-  
13       graph (2)(A).

14          “(B) PRIMARY AND PREVENTIVE CARE.—  
15       Not later than 36 months after the date of en-  
16       actment of this Act, the Secretary shall develop  
17       not less than 10 measures described in para-  
18       graph (2)(B).”.

19       (b) HOSPITAL-ACQUIRED CONDITIONS.—Section  
20       1890A of the Social Security Act, as amended by section  
21       3013(b), is amended by adding at the end the following  
22       new subsection:

23          “(f) HOSPITAL ACQUIRED CONDITIONS.—The Sec-  
24       retary shall, to the extent practicable, publicly report on  
25       measures for hospital-acquired conditions that are cur-

1 rently utilized by the Centers for Medicare & Medicaid  
2 Services for the adjustment of the amount of payment to  
3 hospitals based on rates of hospital-acquired infections.”.

4 (c) CLINICAL PRACTICE GUIDELINES.—Section  
5 304(b) of the Medicare Improvements for Patients and  
6 Providers Act of 2008 (Public Law 110–275) is amended  
7 by adding at the end the following new paragraph:

8 “(4) IDENTIFICATION.—

9 “(A) IN GENERAL.—Following receipt of  
10 the report submitted under paragraph (2), and  
11 not less than every 3 years thereafter, the Sec-  
12 retary shall contract with the Institute to em-  
13 ploy the results of the study performed under  
14 paragraph (1) and the best methods identified  
15 by the Institute for the purpose of identifying  
16 existing and new clinical practice guidelines  
17 that were developed using such best methods,  
18 including guidelines listed in the National  
19 Guideline Clearinghouse.

20 “(B) CONSULTATION.—In carrying out the  
21 identification process under subparagraph (A),  
22 the Secretary shall allow for consultation with  
23 professional societies, voluntary health care or-  
24 ganizations, and expert panels.”.

1 **SEC. 10304. SELECTION OF EFFICIENCY MEASURES.**

2 Sections 1890(b)(7) and 1890A of the Social Security  
3 Act, as added by section 3014, are amended by striking  
4 “quality” each place it appears and inserting “quality and  
5 efficiency”.

6 **SEC. 10305. DATA COLLECTION; PUBLIC REPORTING.**

7 Section 399II(a) of the Public Health Service Act,  
8 as added by section 3015, is amended to read as follows:

9 “(a) IN GENERAL.—

10 “(1) ESTABLISHMENT OF STRATEGIC FRAME-  
11 WORK.—The Secretary shall establish and imple-  
12 ment an overall strategic framework to carry out the  
13 public reporting of performance information, as de-  
14 scribed in section 399JJ. Such strategic framework  
15 may include methods and related timelines for im-  
16 plementing nationally consistent data collection, data  
17 aggregation, and analysis methods.

18 “(2) COLLECTION AND AGGREGATION OF  
19 DATA.—The Secretary shall collect and aggregate  
20 consistent data on quality and resource use meas-  
21 ures from information systems used to support  
22 health care delivery, and may award grants or con-  
23 tracts for this purpose. The Secretary shall align  
24 such collection and aggregation efforts with the re-  
25 quirements and assistance regarding the expansion  
26 of health information technology systems, the inter-

1 operability of such technology systems, and related  
2 standards that are in effect on the date of enact-  
3 ment of the Patient Protection and Affordable Care  
4 Act.

5 “(3) SCOPE.—The Secretary shall ensure that  
6 the data collection, data aggregation, and analysis  
7 systems described in paragraph (1) involve an in-  
8 creasingly broad range of patient populations, pro-  
9 viders, and geographic areas over time.”.

10 **SEC. 10306. IMPROVEMENTS UNDER THE CENTER FOR**  
11 **MEDICARE AND MEDICAID INNOVATION.**

12 Section 1115A of the Social Security Act, as added  
13 by section 3021, is amended—

14 (1) in subsection (a), by inserting at the end  
15 the following new paragraph:

16 “(5) TESTING WITHIN CERTAIN GEOGRAPHIC  
17 AREAS.—For purposes of testing payment and serv-  
18 ice delivery models under this section, the Secretary  
19 may elect to limit testing of a model to certain geo-  
20 graphic areas.”;

21 (2) in subsection (b)(2)—

22 (A) in subparagraph (A)—

23 (i) in the second sentence, by striking  
24 “the preceding sentence may include” and

1 inserting “this subparagraph may include,  
2 but are not limited to,”; and

3 (ii) by inserting after the first sen-  
4 tence the following new sentence: “The  
5 Secretary shall focus on models expected to  
6 reduce program costs under the applicable  
7 title while preserving or enhancing the  
8 quality of care received by individuals re-  
9 ceiving benefits under such title.”;

10 (B) in subparagraph (B), by adding at the  
11 end the following new clauses:

12 “(xix) Utilizing, in particular in enti-  
13 ties located in medically underserved areas  
14 and facilities of the Indian Health Service  
15 (whether operated by such Service or by an  
16 Indian tribe or tribal organization (as  
17 those terms are defined in section 4 of the  
18 Indian Health Care Improvement Act)),  
19 telehealth services—

20 “(I) in treating behavioral health  
21 issues (such as post-traumatic stress  
22 disorder) and stroke; and

23 “(II) to improve the capacity of  
24 non-medical providers and non-spe-  
25 cialized medical providers to provide

1 health services for patients with  
2 chronic complex conditions.

3 “(xx) Utilizing a diverse network of  
4 providers of services and suppliers to im-  
5 prove care coordination for applicable indi-  
6 viduals described in subsection (a)(4)(A)(i)  
7 with 2 or more chronic conditions and a  
8 history of prior-year hospitalization  
9 through interventions developed under the  
10 Medicare Coordinated Care Demonstration  
11 Project under section 4016 of the Bal-  
12 anced Budget Act of 1997 (42 U.S.C.  
13 1395b–1 note).”; and

14 (C) in subparagraph (C), by adding at the  
15 end the following new clause:

16 “(viii) Whether the model dem-  
17 onstrates effective linkage with other pub-  
18 lic sector or private sector payers.”;

19 (3) in subsection (b)(4), by adding at the end  
20 the following new subparagraph:

21 “(C) MEASURE SELECTION.—To the ex-  
22 tent feasible, the Secretary shall select meas-  
23 ures under this paragraph that reflect national  
24 priorities for quality improvement and patient-

1 centered care consistent with the measures de-  
2 scribed in 1890(b)(7)(B).”; and

3 (4) in subsection (c)—

4 (A) in paragraph (1)(B), by striking “care  
5 and reduce spending; and” and inserting “pa-  
6 tient care without increasing spending;”;

7 (B) in paragraph (2), by striking “reduce  
8 program spending under applicable titles.” and  
9 inserting “reduce (or would not result in any  
10 increase in) net program spending under appli-  
11 cable titles; and”; and

12 (C) by adding at the end the following:

13 “(3) the Secretary determines that such expan-  
14 sion would not deny or limit the coverage or provi-  
15 sion of benefits under the applicable title for applica-  
16 ble individuals.

17 In determining which models or demonstration projects to  
18 expand under the preceding sentence, the Secretary shall  
19 focus on models and demonstration projects that improve  
20 the quality of patient care and reduce spending.”.

21 **SEC. 10307. IMPROVEMENTS TO THE MEDICARE SHARED**  
22 **SAVINGS PROGRAM.**

23 Section 1899 of the Social Security Act, as added by  
24 section 3022, is amended by adding at the end the fol-  
25 lowing new subsections:

1 “(i) OPTION TO USE OTHER PAYMENT MODELS.—

2 “(1) IN GENERAL.—If the Secretary determines  
3 appropriate, the Secretary may use any of the pay-  
4 ment models described in paragraph (2) or (3) for  
5 making payments under the program rather than  
6 the payment model described in subsection (d).

7 “(2) PARTIAL CAPITATION MODEL.—

8 “(A) IN GENERAL.—Subject to subpara-  
9 graph (B), a model described in this paragraph  
10 is a partial capitation model in which an ACO  
11 is at financial risk for some, but not all, of the  
12 items and services covered under parts A and  
13 B, such as at risk for some or all physicians’  
14 services or all items and services under part B.  
15 The Secretary may limit a partial capitation  
16 model to ACOs that are highly integrated sys-  
17 tems of care and to ACOs capable of bearing  
18 risk, as determined to be appropriate by the  
19 Secretary.

20 “(B) NO ADDITIONAL PROGRAM EXPENDI-  
21 TURES.—Payments to an ACO for items and  
22 services under this title for beneficiaries for a  
23 year under the partial capitation model shall be  
24 established in a manner that does not result in  
25 spending more for such ACO for such bene-

1           ficiaries than would otherwise be expended for  
2           such ACO for such beneficiaries for such year  
3           if the model were not implemented, as esti-  
4           mated by the Secretary.

5           “(3) OTHER PAYMENT MODELS.—

6                   “(A) IN GENERAL.—Subject to subpara-  
7           graph (B), a model described in this paragraph  
8           is any payment model that the Secretary deter-  
9           mines will improve the quality and efficiency of  
10          items and services furnished under this title.

11                   “(B) NO ADDITIONAL PROGRAM EXPENDI-  
12          TURES.—Subparagraph (B) of paragraph (2)  
13          shall apply to a payment model under subpara-  
14          graph (A) in a similar manner as such subpara-  
15          graph (B) applies to the payment model under  
16          paragraph (2).

17          “(j) INVOLVEMENT IN PRIVATE PAYER AND OTHER  
18          THIRD PARTY ARRANGEMENTS.—The Secretary may give  
19          preference to ACOs who are participating in similar ar-  
20          rangements with other payers.

21                   “(k) TREATMENT OF PHYSICIAN GROUP PRACTICE  
22          DEMONSTRATION.—During the period beginning on the  
23          date of the enactment of this section and ending on the  
24          date the program is established, the Secretary may enter  
25          into an agreement with an ACO under the demonstration

1 under section 1866A, subject to rebasing and other modi-  
2 fications deemed appropriate by the Secretary.”.

3 **SEC. 10308. REVISIONS TO NATIONAL PILOT PROGRAM ON**  
4 **PAYMENT BUNDLING.**

5 (a) IN GENERAL.—Section 1866D of the Social Secu-  
6 rity Act, as added by section 3023, is amended—

7 (1) in paragraph (a)(2)(B), in the matter pre-  
8 ceding clause (i), by striking “8 conditions” and in-  
9 serting “10 conditions”;

10 (2) by striking subsection (c)(1)(B) and insert-  
11 ing the following:

12 “(B) EXPANSION.—The Secretary may, at  
13 any point after January 1, 2016, expand the  
14 duration and scope of the pilot program, to the  
15 extent determined appropriate by the Secretary,  
16 if—

17 “(i) the Secretary determines that  
18 such expansion is expected to—

19 “(I) reduce spending under title  
20 XVIII of the Social Security Act with-  
21 out reducing the quality of care; or

22 “(II) improve the quality of care  
23 and reduce spending;

24 “(ii) the Chief Actuary of the Centers  
25 for Medicare & Medicaid Services certifies

1           that such expansion would reduce program  
2           spending under such title XVIII; and

3                   “(iii) the Secretary determines that  
4           such expansion would not deny or limit the  
5           coverage or provision of benefits under this  
6           title for individuals.”; and

7           (3) by striking subsection (g) and inserting the  
8           following new subsection:

9           “(g) APPLICATION OF PILOT PROGRAM TO CON-  
10          TINUING CARE HOSPITALS.—

11                   “(1) IN GENERAL.—In conducting the pilot pro-  
12           gram, the Secretary shall apply the provisions of the  
13           program so as to separately pilot test the continuing  
14           care hospital model.

15                   “(2) SPECIAL RULES.—In pilot testing the con-  
16           tinuing care hospital model under paragraph (1), the  
17           following rules shall apply:

18                           “(A) Such model shall be tested without  
19           the limitation to the conditions selected under  
20           subsection (a)(2)(B).

21                           “(B)       Notwithstanding       subsection  
22           (a)(2)(D), an episode of care shall be defined as  
23           the full period that a patient stays in the con-  
24           tinuing care hospital plus the first 30 days fol-  
25           lowing discharge from such hospital.

1           “(3) CONTINUING CARE HOSPITAL DEFINED.—

2           In this subsection, the term ‘continuing care hos-  
3           pital’ means an entity that has demonstrated the  
4           ability to meet patient care and patient safety stand-  
5           ards and that provides under common management  
6           the medical and rehabilitation services provided in  
7           inpatient rehabilitation hospitals and units (as de-  
8           fined in section 1886(d)(1)(B)(ii)), long term care  
9           hospitals (as defined in section 1886(d)(1)(B)(iv)(I)),  
10          and skilled nursing facilities (as defined in section  
11          1819(a)) that are located in a hospital described in  
12          section 1886(d).”.

13          (b) TECHNICAL AMENDMENTS.—

14                 (1) Section 3023 is amended by striking  
15                 “1886C” and inserting “1866C”.

16                 (2) Title XVIII of the Social Security Act is  
17                 amended by redesignating section 1866D, as added  
18                 by section 3024, as section 1866E.

19   **SEC. 10309. REVISIONS TO HOSPITAL READMISSIONS RE-**  
20                                 **DUCTION PROGRAM.**

21                 Section 1886(q)(1) of the Social Security Act, as  
22                 added by section 3025, in the matter preceding subpara-  
23                 graph (A), is amended by striking “the Secretary shall re-  
24                 duce the payments” and all that follows through “the  
25                 product of” and inserting “the Secretary shall make pay-

1 ments (in addition to the payments described in paragraph  
2 (2)(A)(ii)) for such a discharge to such hospital under  
3 subsection (d) (or section 1814(b)(3), as the case may be)  
4 in an amount equal to the product of”.

5 **SEC. 10310. REPEAL OF PHYSICIAN PAYMENT UPDATE.**

6 The provisions of, and the amendment made by, sec-  
7 tion 3101 are repealed

8 **SEC. 10311. REVISIONS TO EXTENSION OF AMBULANCE**  
9 **ADD-ONS.**

10 (a) GROUND AMBULANCE.—Section 1834(l)(13)(A)  
11 of the Social Security Act (42 U.S.C. 1395m(l)(13)(A)),  
12 as amended by section 3105(a), is further amended—

13 (1) in the matter preceding clause (i)—

14 (A) by striking “2007, for” and inserting  
15 “2007, and for”; and

16 (B) by striking “2010, and for such serv-  
17 ices furnished on or after April 1, 2010, and  
18 before January 1, 2011” and inserting “2011”;  
19 and

20 (2) in each of clauses (i) and (ii)—

21 (A) by striking “, and on or after April 1,  
22 2010, and before January 1, 2011” each place  
23 it appears; and

1 (B) by striking “January 1, 2010” and in-  
2 serting “January 1, 2011” each place it ap-  
3 pears.

4 (b) AIR AMBULANCE.—Section 146(b)(1) of the  
5 Medicare Improvements for Patients and Providers Act of  
6 2008 (Public Law 110–275), as amended by section  
7 3105(b), is further amended by striking “December 31,  
8 2009, and during the period beginning on April 1, 2010,  
9 and ending on January 1, 2011” and inserting “December  
10 31, 2010”.

11 (c) SUPER RURAL AMBULANCE.—Section  
12 1834(l)(12)(A) of the Social Security Act (42 U.S.C.  
13 1395m(l)(12)(A)), as amended by section 3105(c), is fur-  
14 ther amended by striking “2010, and on or after April  
15 1, 2010, and before January 1, 2011” and inserting  
16 “2011”.

17 **SEC. 10312. CERTAIN PAYMENT RULES FOR LONG-TERM**  
18 **CARE HOSPITAL SERVICES AND MORATO-**  
19 **RIUM ON THE ESTABLISHMENT OF CERTAIN**  
20 **HOSPITALS AND FACILITIES.**

21 (a) CERTAIN PAYMENT RULES.—Section 114(c) of  
22 the Medicare, Medicaid, and SCHIP Extension Act of  
23 2007 (42 U.S.C. 1395ww note), as amended by section  
24 4302(a) of the American Recovery and Reinvestment Act  
25 (Public Law 111–5) and section 3106(a) of this Act, is

1 further amended by striking “4-year period” each place  
2 it appears and inserting “5-year period”.

3 (b) MORATORIUM.—Section 114(d) of such Act (42  
4 U.S.C. 1395ww note), as amended by section 3106(b) of  
5 this Act, in the matter preceding subparagraph (A), is  
6 amended by striking “4-year period” and inserting “5-  
7 year period”.

8 **SEC. 10313. REVISIONS TO THE EXTENSION FOR THE**  
9 **RURAL COMMUNITY HOSPITAL DEMONSTRATION PROGRAM.**  
10

11 (a) IN GENERAL.—Subsection (g) of section 410A of  
12 the Medicare Prescription Drug, Improvement, and Mod-  
13 ernization Act of 2003 (Public Law 108–173; 117 Stat.  
14 2272), as added by section 3123(a) of this Act, is amend-  
15 ed to read as follows:

16 “(g) FIVE-YEAR EXTENSION OF DEMONSTRATION  
17 PROGRAM.—

18 “(1) IN GENERAL.—Subject to the succeeding  
19 provisions of this subsection, the Secretary shall con-  
20 duct the demonstration program under this section  
21 for an additional 5-year period (in this section re-  
22 ferred to as the ‘5-year extension period’) that be-  
23 gins on the date immediately following the last day  
24 of the initial 5-year period under subsection (a)(5).

1           “(2)    EXPANSION    OF    DEMONSTRATION  
2    STATES.—Notwithstanding subsection (a)(2), during  
3    the 5-year extension period, the Secretary shall ex-  
4    pand the number of States with low population den-  
5    sities determined by the Secretary under such sub-  
6    section to 20. In determining which States to include  
7    in such expansion, the Secretary shall use the same  
8    criteria and data that the Secretary used to deter-  
9    mine the States under such subsection for purposes  
10   of the initial 5-year period.

11           “(3) INCREASE IN MAXIMUM NUMBER OF HOS-  
12   PITALS PARTICIPATING IN THE DEMONSTRATION  
13   PROGRAM.—Notwithstanding subsection (a)(4), dur-  
14   ing the 5-year extension period, not more than 30  
15   rural community hospitals may participate in the  
16   demonstration program under this section.

17           “(4) HOSPITALS IN DEMONSTRATION PROGRAM  
18   ON DATE OF ENACTMENT.—In the case of a rural  
19   community hospital that is participating in the dem-  
20   onstration program under this section as of the last  
21   day of the initial 5-year period, the Secretary—

22           “(A) shall provide for the continued par-  
23   ticipation of such rural community hospital in  
24   the demonstration program during the 5-year  
25   extension period unless the rural community

1 hospital makes an election, in such form and  
2 manner as the Secretary may specify, to dis-  
3 continue such participation; and

4 “(B) in calculating the amount of payment  
5 under subsection (b) to the rural community  
6 hospital for covered inpatient hospital services  
7 furnished by the hospital during such 5-year ex-  
8 tension period, shall substitute, under para-  
9 graph (1)(A) of such subsection—

10 “(i) the reasonable costs of providing  
11 such services for discharges occurring in  
12 the first cost reporting period beginning on  
13 or after the first day of the 5-year exten-  
14 sion period, for

15 “(ii) the reasonable costs of providing  
16 such services for discharges occurring in  
17 the first cost reporting period beginning on  
18 or after the implementation of the dem-  
19 onstration program.”.

20 (b) CONFORMING AMENDMENTS.—Subsection (a)(5)  
21 of section 410A of the Medicare Prescription Drug, Im-  
22 provement, and Modernization Act of 2003 (Public Law  
23 108–173; 117 Stat. 2272), as amended by section 3123(b)  
24 of this Act, is amended by striking “1-year extension” and  
25 inserting “5-year extension”.

1 **SEC. 10314. ADJUSTMENT TO LOW-VOLUME HOSPITAL PRO-**  
2 **VISION.**

3 Section 1886(d)(12) of the Social Security Act (42  
4 U.S.C. 1395ww(d)(12), as amended by section 3125, is  
5 amended—

6 (1) in subparagraph (C)(i), by striking “1,500  
7 discharges” and inserting “1,600 discharges”; and

8 (2) in subparagraph (D), by striking “1,500  
9 discharges” and inserting “1,600 discharges”.

10 **SEC. 10315. REVISIONS TO HOME HEALTH CARE PROVI-**  
11 **SIONS.**

12 (a) **REBASING.**—Section 1895(b)(3)(A)(iii) of the So-  
13 cial Security Act, as added by section 3131, is amended—

14 (1) in the clause heading, by striking “2013”  
15 and inserting “2014”;

16 (2) in subclause (I), by striking “2013” and in-  
17 sserting “2014”; and

18 (3) in subclause (II), by striking “2016” and  
19 inserting “2017”.

20 (b) **REVISION OF HOME HEALTH STUDY AND RE-**  
21 **PORT.**—Section 3131(d) is amended to read as follows:

22 “(d) **STUDY AND REPORT ON THE DEVELOPMENT OF**  
23 **HOME HEALTH PAYMENT REVISIONS IN ORDER TO EN-**  
24 **SURE ACCESS TO CARE AND PAYMENT FOR SEVERITY OF**  
25 **ILLNESS.**—

1           “(1) IN GENERAL.—The Secretary of Health  
2           and Human Services (in this section referred to as  
3           the ‘Secretary’) shall conduct a study on home  
4           health agency costs involved with providing ongoing  
5           access to care to low-income Medicare beneficiaries  
6           or beneficiaries in medically underserved areas, and  
7           in treating beneficiaries with varying levels of sever-  
8           ity of illness. In conducting the study, the Secretary  
9           may analyze items such as the following:

10                   “(A) Methods to potentially revise the  
11                   home health prospective payment system under  
12                   section 1895 of the Social Security Act (42  
13                   U.S.C. 1395fff) to account for costs related to  
14                   patient severity of illness or to improving bene-  
15                   ficiary access to care, such as—

16                           “(i) payment adjustments for services  
17                           that may involve additional or fewer re-  
18                           sources;

19                           “(ii) changes to reflect resources in-  
20                           volved with providing home health services  
21                           to low-income Medicare beneficiaries or  
22                           Medicare beneficiaries residing in medically  
23                           underserved areas;

24                           “(iii) ways outlier payments might be  
25                           revised to reflect costs of treating Medicare

1 beneficiaries with high levels of severity of  
2 illness; and

3 “(iv) other issues determined appro-  
4 priate by the Secretary.

5 “(B) Operational issues involved with po-  
6 tential implementation of potential revisions to  
7 the home health payment system, including im-  
8 pacts for both home health agencies and admin-  
9 istrative and systems issues for the Centers for  
10 Medicare & Medicaid Services, and any possible  
11 payment vulnerabilities associated with imple-  
12 menting potential revisions.

13 “(C) Whether additional research might be  
14 needed.

15 “(D) Other items determined appropriate  
16 by the Secretary.

17 “(2) CONSIDERATIONS.—In conducting the  
18 study under paragraph (1), the Secretary may con-  
19 sider whether patient severity of illness and access  
20 to care could be measured by factors, such as—

21 “(A) population density and relative pa-  
22 tient access to care;

23 “(B) variations in service costs for pro-  
24 viding care to individuals who are dually eligible  
25 under the Medicare and Medicaid programs;

1           “(C) the presence of severe or chronic dis-  
2           eases, which might be measured by multiple,  
3           discontinuous home health episodes;

4           “(D) poverty status, such as evidenced by  
5           the receipt of Supplemental Security Income  
6           under title XVI of the Social Security Act; and

7           “(E) other factors determined appropriate  
8           by the Secretary.

9           “(3) REPORT.—Not later than March 1, 2014,  
10          the Secretary shall submit to Congress a report on  
11          the study conducted under paragraph (1), together  
12          with recommendations for such legislation and ad-  
13          ministrative action as the Secretary determines ap-  
14          propriate.

15          “(4) CONSULTATIONS.—In conducting the  
16          study under paragraph (1), the Secretary shall con-  
17          sult with appropriate stakeholders, such as groups  
18          representing home health agencies and groups rep-  
19          resenting Medicare beneficiaries.

20          “(5) MEDICARE DEMONSTRATION PROJECT  
21          BASED ON THE RESULTS OF THE STUDY.—

22          “(A) IN GENERAL.—Subject to subpara-  
23          graph (D), taking into account the results of  
24          the study conducted under paragraph (1), the  
25          Secretary may, as determined appropriate, pro-

1           vide for a demonstration project to test whether  
2           making payment adjustments for home health  
3           services under the Medicare program would  
4           substantially improve access to care for patients  
5           with high severity levels of illness or for low-in-  
6           come or underserved Medicare beneficiaries.

7           “(B) WAIVING BUDGET NEUTRALITY.—  
8           The Secretary shall not reduce the standard  
9           prospective payment amount (or amounts)  
10          under section 1895 of the Social Security Act  
11          (42 U.S.C. 1395fff) applicable to home health  
12          services furnished during a period to offset any  
13          increase in payments during such period result-  
14          ing from the application of the payment adjust-  
15          ments under subparagraph (A).

16          “(C) NO EFFECT ON SUBSEQUENT PERI-  
17          ODS.—A payment adjustment resulting from  
18          the application of subparagraph (A) for a pe-  
19          riod—

20                 “(i) shall not apply to payments for  
21                 home health services under title XVIII  
22                 after such period; and

23                 “(ii) shall not be taken into account in  
24                 calculating the payment amounts applica-  
25                 ble for such services after such period.

1           “(D) DURATION.—If the Secretary deter-  
2 mines it appropriate to conduct the demonstra-  
3 tion project under this subsection, the Secretary  
4 shall conduct the project for a four year period  
5 beginning not later than January 1, 2015.

6           “(E) FUNDING.—The Secretary shall pro-  
7 vide for the transfer from the Federal Hospital  
8 Insurance Trust Fund under section 1817 of  
9 the Social Security Act (42 U.S.C. 1395i) and  
10 the Federal Supplementary Medical Insurance  
11 Trust Fund established under section 1841 of  
12 such Act (42 U.S.C. 1395t), in such proportion  
13 as the Secretary determines appropriate, of  
14 \$500,000,000 for the period of fiscal years  
15 2015 through 2018. Such funds shall be made  
16 available for the study described in paragraph  
17 (1) and the design, implementation and evalua-  
18 tion of the demonstration described in this  
19 paragraph. Amounts available under this sub-  
20 paragraph shall be available until expended.

21           “(F) EVALUATION AND REPORT.—If the  
22 Secretary determines it appropriate to conduct  
23 the demonstration project under this sub-  
24 section, the Secretary shall—

1 “(i) provide for an evaluation of the  
2 project; and

3 “(ii) submit to Congress, by a date  
4 specified by the Secretary, a report on the  
5 project.

6 “(G) ADMINISTRATION.—Chapter 35 of  
7 title 44, United States Code, shall not apply  
8 with respect to this subsection.”.

9 **SEC. 10316. MEDICARE DSH.**

10 Section 1886(r)(2)(B) of the Social Security Act, as  
11 added by section 3133, is amended—

12 (1) in clause (i)—

13 (A) in the matter preceding subclause (I),  
14 by striking “(divided by 100)”;

15 (B) in subclause (I), by striking “2012”  
16 and inserting “2013”;

17 (C) in subclause (II), by striking the pe-  
18 riod at the end and inserting a comma; and

19 (D) by adding at the end the following  
20 flush matter:

21 “minus 1.5 percentage points.”.

22 (2) in clause (ii)—

23 (A) in the matter preceding subclause (I),  
24 by striking “(divided by 100)”;

1 (B) in subclause (I), by striking “2012”  
2 and inserting “2013”;

3 (C) in subelause (II), by striking the pe-  
4 riod at the end and inserting a comma; and

5 (D) by adding at the end the following  
6 flush matter:

7 “and, for each of 2018 and 2019, minus  
8 1.5 percentage points.”.

9 **SEC. 10317. REVISIONS TO EXTENSION OF SECTION 508**

10 **HOSPITAL PROVISIONS.**

11 Section 3137(a) is amended to read as follows:

12 “(a) EXTENSION.—

13 “(1) IN GENERAL.—Subsection (a) of section  
14 106 of division B of the Tax Relief and Health Care  
15 Act of 2006 (42 U.S.C. 1395 note), as amended by  
16 section 117 of the Medicare, Medicaid, and SCHIP  
17 Extension Act of 2007 (Public Law 110–173) and  
18 section 124 of the Medicare Improvements for Pa-  
19 tients and Providers Act of 2008 (Public Law 110–  
20 275), is amended by striking ‘September 30, 2009’  
21 and inserting ‘September 30, 2010’.

22 “(2) SPECIAL RULE FOR FISCAL YEAR 2010.—

23 “(A) IN GENERAL.—Subject to subpara-  
24 graph (B), for purposes of implementation of  
25 the amendment made by paragraph (1), includ-

1           ing (notwithstanding paragraph (3) of section  
2           117(a) of the Medicare, Medicaid and SCHIP  
3           Extension Act of 2007 (Public Law 110–173),  
4           as amended by section 124(b) of the Medicare  
5           Improvements for Patients and Providers Act of  
6           2008 (Public Law 110–275)) for purposes of  
7           the implementation of paragraph (2) of such  
8           section 117(a), during fiscal year 2010, the  
9           Secretary of Health and Human Services (in  
10          this subsection referred to as the ‘Secretary’)  
11          shall use the hospital wage index that was pro-  
12          mulgated by the Secretary in the Federal Reg-  
13          ister on August 27, 2009 (74 Fed. Reg.  
14          43754), and any subsequent corrections.

15                 “(B) EXCEPTION.—Beginning on April 1,  
16                 2010, in determining the wage index applicable  
17                 to hospitals that qualify for wage index reclassi-  
18                 fication, the Secretary shall include the average  
19                 hourly wage data of hospitals whose reclassi-  
20                 fication was extended pursuant to the amend-  
21                 ment made by paragraph (1) only if including  
22                 such data results in a higher applicable reclassi-  
23                 fied wage index.

24                 “(3) ADJUSTMENT FOR CERTAIN HOSPITALS IN  
25                 FISCAL YEAR 2010.—

1           “(A) IN GENERAL.—In the case of a sub-  
2           section (d) hospital (as defined in subsection  
3           (d)(1)(B) of section 1886 of the Social Security  
4           Act (42 U.S.C. 1395ww)) with respect to  
5           which—

6                   “(i) a reclassification of its wage  
7                   index for purposes of such section was ex-  
8                   tended pursuant to the amendment made  
9                   by paragraph (1); and

10                   “(ii) the wage index applicable for  
11                   such hospital for the period beginning on  
12                   October 1, 2009, and ending on March 31,  
13                   2010, was lower than for the period begin-  
14                   ning on April 1, 2010, and ending on Sep-  
15                   tember 30, 2010, by reason of the applica-  
16                   tion of paragraph (2)(B);

17           the Secretary shall pay such hospital an addi-  
18           tional payment that reflects the difference be-  
19           tween the wage index for such periods.

20           “(B) TIMEFRAME FOR PAYMENTS.—The  
21           Secretary shall make payments required under  
22           subparagraph by not later than December 31,  
23           2010.”.

1 **SEC. 10318. REVISIONS TO TRANSITIONAL EXTRA BENEFITS**  
2 **UNDER MEDICARE ADVANTAGE.**

3 Section 1853(p)(3)(A) of the Social Security Act, as  
4 added by section 3201(h), is amended by inserting “in  
5 2009” before the period at the end.

6 **SEC. 10319. REVISIONS TO MARKET BASKET ADJUSTMENTS.**

7 (a) **INPATIENT ACUTE HOSPITALS.**—Section  
8 1886(b)(3)(B)(xii) of the Social Security Act, as added by  
9 section 3401(a), is amended—

10 (1) in subclause (I), by striking “and” at the  
11 end;

12 (2) by redesignating subclause (II) as subclause  
13 (III);

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

16 “(II) for each of fiscal years 2012 and 2013, by  
17 0.1 percentage point; and”; and

18 (4) in subclause (III), as redesignated by para-  
19 graph (2), by striking “2012” and inserting “2014”.

20 (b) **LONG-TERM CARE HOSPITALS.**—Section  
21 1886(m)(4) of the Social Security Act, as added by section  
22 3401(c), is amended—

23 (1) in subparagraph (A)—

24 (A) in clause (i)—

1 (i) by striking “each of rate years  
2 2010 and 2011” and inserting “rate year  
3 2010”; and

4 (ii) by striking “and” at the end;  
5 (B) by redesignating clause (ii) as clause  
6 (iv);

7 (C) by inserting after clause (i) the fol-  
8 lowing new clauses:

9 “(ii) for rate year 2011, 0.50 percent-  
10 age point;

11 “(iii) for each of the rate years begin-  
12 ning in 2012 and 2013, 0.1 percentage  
13 point; and”; and

14 (D) in clause (iv), as redesignated by sub-  
15 paragraph (B), by striking “2012” and insert-  
16 ing “2014”; and

17 (2) in subparagraph (B), by striking “(A)(ii)”  
18 and inserting “(A)(iv)”.

19 (c) INPATIENT REHABILITATION FACILITIES.—Sec-  
20 tion 1886(j)(3)(D)(i) of the Social Security Act, as added  
21 by section 3401(d), is amended—

22 (1) in subclause (I), by striking “and” at the  
23 end;

24 (2) by redesignating subclause (II) as subclause  
25 (III);

1           (3) by inserting after subclause (II) the fol-  
2           lowing new subclause:

3                           “(II) for each of fiscal years  
4                           2012 and 2013, 0.1 percentage point;  
5                           and”;

6           (4) in subclause (III), as redesignated by para-  
7           graph (2), by striking “2012” and inserting “2014”.

8           (d)     HOME     HEALTH     AGENCIES.—Section  
9     1895(b)(3)(B)(vi)(II) of such Act, as added by section  
10    3401(e), is amended by striking “and 2012” and inserting  
11    “, 2012, and 2013”.

12          (e)     PSYCHIATRIC     HOSPITALS.—Section  
13    1886(s)(3)(A) of the Social Security Act, as added by sec-  
14    tion 3401(f), is amended—

15           (1) in clause (i), by striking “and” at the end;

16           (2) by redesignating clause (ii) as clause (iii);

17           (3) by inserting after clause (ii) the following  
18    new clause:

19                           “(ii) for each of the rate years begin-  
20                           ning in 2012 and 2013, 0.1 percentage  
21                           point; and”;

22           (4) in clause (iii), as redesignated by paragraph  
23    (2), by striking “2012” and inserting “2014”.

1 (f) HOSPICE CARE.—Section 1814(i)(1)(C) of the So-  
2 cial Security Act (42 U.S.C. 1395f(i)(1)(C)), as amended  
3 by section 3401(g), is amended—

4 (1) in clause (iv)(II), by striking “0.5” and in-  
5 serting “0.3”; and

6 (2) in clause (v), in the matter preceding sub-  
7 clause (I), by striking “0.5” and inserting “0.3”.

8 (g) OUTPATIENT HOSPITALS.—Section  
9 1833(t)(3)(G)(i) of the Social Security Act, as added by  
10 section 3401(i), is amended—

11 (1) in subclause (I), by striking “and” at the  
12 end;

13 (2) by redesignating subclause (II) as subclause  
14 (III);

15 (3) by inserting after subclause (II) the fol-  
16 lowing new subclause:

17 “(II) for each of 2012 and 2013,  
18 0.1 percentage point; and”;

19 (4) in subclause (III), as redesignated by para-  
20 graph (2), by striking “2012” and inserting “2014”.

21 **SEC. 10320. EXPANSION OF THE SCOPE OF, AND ADDI-**  
22 **TIONAL IMPROVEMENTS TO, THE INDE-**  
23 **PENDENT MEDICARE ADVISORY BOARD.**

24 (a) IN GENERAL.—Section 1899A of the Social Secu-  
25 rity Act, as added by section 3403, is amended—

1 (1) in subsection (c)—

2 (A) in paragraph (1)(B), by adding at the  
3 end the following new sentence: “In any year  
4 (beginning with 2014) that the Board is not re-  
5 quired to submit a proposal under this section,  
6 the Board shall submit to Congress an advisory  
7 report on matters related to the Medicare pro-  
8 gram.”;

9 (B) in paragraph (2)(A)—

10 (i) in clause (iv), by inserting “or the  
11 full premium subsidy under section  
12 1860D–14(a)” before the period at the end  
13 of the last sentence; and

14 (ii) by adding at the end the following  
15 new clause:

16 “(vii) If the Chief Actuary of the Cen-  
17 ters for Medicare & Medicaid Services has  
18 made a determination described in sub-  
19 section (e)(3)(B)(i)(II) in the determina-  
20 tion year, the proposal shall be designed to  
21 help reduce the growth rate described in  
22 paragraph (8) while maintaining or en-  
23 hancing beneficiary access to quality care  
24 under this title.”;

25 (C) in paragraph (2)(B)—

1 (i) in clause (v), by striking “and” at  
2 the end;

3 (ii) in clause (vi), by striking the pe-  
4 riod at the end and inserting “; and”; and

5 (iii) by adding at the end the fol-  
6 lowing new clause:

7 “(vii) take into account the data and  
8 findings contained in the annual reports  
9 under subsection (n) in order to develop  
10 proposals that can most effectively promote  
11 the delivery of efficient, high quality care  
12 to Medicare beneficiaries.”;

13 (D) in paragraph (3)—

14 (i) in the heading, by striking  
15 “TRANSMISSION OF BOARD PROPOSAL TO  
16 PRESIDENT” and inserting “SUBMISSION  
17 OF BOARD PROPOSAL TO CONGRESS AND  
18 THE PRESIDENT”;

19 (ii) in subparagraph (A)(i), by strik-  
20 ing “transmit a proposal under this section  
21 to the President” and insert “submit a  
22 proposal under this section to Congress  
23 and the President”; and

24 (iii) in subparagraph (A)(ii)—

- 1 (I) in subclause (I), by inserting  
2 “or” at the end;
- 3 (II) in subclause (II), by striking  
4 “; or” and inserting a period; and  
5 (III) by striking subclause (III);  
6 (E) in paragraph (4)—  
7 (i) by striking “the Board under para-  
8 graph (3)(A)(i) or”; and  
9 (ii) by striking “immediately” and in-  
10 sserting “within 2 days”;
- 11 (F) in paragraph (5)—  
12 (i) by striking “to but” and inserting  
13 “but”; and  
14 (ii) by inserting “Congress and” after  
15 “submit a proposal to”; and  
16 (G) in paragraph (6)(B)(i), by striking  
17 “per unduplicated enrollee” and inserting “(cal-  
18 culated as the sum of per capita spending  
19 under each of parts A, B, and D)”;
- 20 (2) in subsection (d)—  
21 (A) in paragraph (1)(A)—  
22 (i) by inserting “the Board or” after  
23 “a proposal is submitted by”; and

1 (ii) by inserting “subsection  
2 (c)(3)(A)(i) or” after “the Senate under”;  
3 and

4 (B) in paragraph (2)(A), by inserting “the  
5 Board or” after “a proposal is submitted by”;  
6 (3) in subsection (e)—

7 (A) in paragraph (1), by inserting “the  
8 Board or” after “a proposal submitted by”; and

9 (B) in paragraph (3)—

10 (i) by striking “EXCEPTION.—The  
11 Secretary shall not be required to imple-  
12 ment the recommendations contained in a  
13 proposal submitted in a proposal year by”  
14 and inserting “EXCEPTIONS.—

15 “(A) IN GENERAL.—The Secretary shall  
16 not implement the recommendations contained  
17 in a proposal submitted in a proposal year by  
18 the Board or”;

19 (ii) by redesignating subparagraphs  
20 (A) and (B) as clauses (i) and (ii), respec-  
21 tively, and indenting appropriately; and

22 (iii) by adding at the end the fol-  
23 lowing new subparagraph:

24 “(B) LIMITED ADDITIONAL EXCEPTION.—

1           “(i) IN GENERAL.—Subject to clause  
2           (ii), the Secretary shall not implement the  
3           recommendations contained in a proposal  
4           submitted by the Board or the President to  
5           Congress pursuant to this section in a pro-  
6           posal year (beginning with proposal year  
7           2019) if—

8                   “(I) the Board was required to  
9                   submit a proposal to Congress under  
10                  this section in the year preceding the  
11                  proposal year; and

12                  “(II) the Chief Actuary of the  
13                  Centers for Medicare & Medicaid  
14                  Services makes a determination in the  
15                  determination year that the growth  
16                  rate described in subsection (c)(8) ex-  
17                  ceeds the growth rate described in  
18                  subsection (c)(6)(A)(i).

19           “(ii) LIMITED ADDITIONAL EXCEP-  
20           TION MAY NOT BE APPLIED IN TWO CON-  
21           SECUTIVE YEARS.—This subparagraph  
22           shall not apply if the recommendations  
23           contained in a proposal submitted by the  
24           Board or the President to Congress pursu-  
25           ant to this section in the year preceding

1 the proposal year were not required to be  
2 implemented by reason of this subpara-  
3 graph.

4 “(iii) NO AFFECT ON REQUIREMENT  
5 TO SUBMIT PROPOSALS OR FOR CONGRES-  
6 SIONAL CONSIDERATION OF PROPOSALS.—  
7 Clause (i) and (ii) shall not affect—

8 “(I) the requirement of the  
9 Board or the President to submit a  
10 proposal to Congress in a proposal  
11 year in accordance with the provisions  
12 of this section; or

13 “(II) Congressional consideration  
14 of a legislative proposal (described in  
15 subsection (c)(3)(B)(iv)) contained  
16 such a proposal in accordance with  
17 subsection (d).”;

18 (4) in subsection (f)(3)(B)—

19 (A) by striking “or advisory reports to  
20 Congress” and inserting “, advisory reports, or  
21 advisory recommendations”; and

22 (B) by inserting “or produce the public re-  
23 port under subsection (n)” after “this section”;  
24 and

1           (5) by adding at the end the following new sub-  
2 sections:

3           “(n) ANNUAL PUBLIC REPORT.—

4           “(1) IN GENERAL.—Not later than July 1,  
5 2014, and annually thereafter, the Board shall  
6 produce a public report containing standardized in-  
7 formation on system-wide health care costs, patient  
8 access to care, utilization, and quality-of-care that  
9 allows for comparison by region, types of services,  
10 types of providers, and both private payers and the  
11 program under this title.

12           “(2) REQUIREMENTS.—Each report produced  
13 pursuant to paragraph (1) shall include information  
14 with respect to the following areas:

15           “(A) The quality and costs of care for the  
16 population at the most local level determined  
17 practical by the Board (with quality and costs  
18 compared to national benchmarks and reflecting  
19 rates of change, taking into account quality  
20 measures described in section 1890(b)(7)(B)).

21           “(B) Beneficiary and consumer access to  
22 care, patient and caregiver experience of care,  
23 and the cost-sharing or out-of-pocket burden on  
24 patients.

1           “(C) Epidemiological shifts and demo-  
2           graphic changes.

3           “(D) The proliferation, effectiveness, and  
4           utilization of health care technologies, including  
5           variation in provider practice patterns and  
6           costs.

7           “(E) Any other areas that the Board de-  
8           termines affect overall spending and quality of  
9           care in the private sector.

10          “(o) ADVISORY RECOMMENDATIONS FOR NON-FED-  
11          ERAL HEALTH CARE PROGRAMS.—

12           “(1) IN GENERAL.—Not later than January 15,  
13          2015, and at least once every two years thereafter,  
14          the Board shall submit to Congress and the Presi-  
15          dent recommendations to slow the growth in na-  
16          tional health expenditures (excluding expenditures  
17          under this title and in other Federal health care pro-  
18          grams) while preserving or enhancing quality of  
19          care, such as recommendations—

20           “(A) that the Secretary or other Federal  
21          agencies can implement administratively;

22           “(B) that may require legislation to be en-  
23          acted by Congress in order to be implemented;

1           “(C) that may require legislation to be en-  
2           acted by State or local governments in order to  
3           be implemented;

4           “(D) that private sector entities can volun-  
5           tarily implement; and

6           “(E) with respect to other areas deter-  
7           mined appropriate by the Board.

8           “(2) COORDINATION.—In making recommenda-  
9           tions under paragraph (1), the Board shall coordi-  
10          nate such recommendations with recommendations  
11          contained in proposals and advisory reports pro-  
12          duced by the Board under subsection (c).

13          “(3) AVAILABLE TO PUBLIC.—The Board shall  
14          make recommendations submitted to Congress and  
15          the President under this subsection available to the  
16          public.”.

17          (b) NAME CHANGE.—Any reference in the provisions  
18          of, or amendments made by, section 3403 to the “Inde-  
19          pendent Medicare Advisory Board” shall be deemed to be  
20          a reference to the “Independent Payment Advisory  
21          Board”.

22          (c) RULE OF CONSTRUCTION.—Nothing in the  
23          amendments made by this section shall preclude the Inde-  
24          pendent Medicare Advisory Board, as established under  
25          section 1899A of the Social Security Act (as added by sec-

1 tion 3403), from solely using data from public or private  
2 sources to carry out the amendments made by subsection  
3 (a)(4).

4 **SEC. 10321. REVISION TO COMMUNITY HEALTH TEAMS.**

5 Section 3502(c)(2)(A) is amended by inserting “or  
6 other primary care providers” after “physicians”.

7 **SEC. 10322. QUALITY REPORTING FOR PSYCHIATRIC HOS-**  
8 **PITALS.**

9 (a) IN GENERAL.—Section 1886(s) of the Social Se-  
10 curity Act, as added by section 3401(f), is amended by  
11 adding at the end the following new paragraph:

12 “(4) QUALITY REPORTING.—

13 “(A) REDUCTION IN UPDATE FOR FAILURE  
14 TO REPORT.—

15 “(i) IN GENERAL.—Under the system  
16 described in paragraph (1), for rate year  
17 2014 and each subsequent rate year, in the  
18 case of a psychiatric hospital or psychiatric  
19 unit that does not submit data to the Sec-  
20 retary in accordance with subparagraph  
21 (C) with respect to such a rate year, any  
22 annual update to a standard Federal rate  
23 for discharges for the hospital during the  
24 rate year, and after application of para-

1 graph (2), shall be reduced by 2 percent-  
2 age points.

3 “(ii) SPECIAL RULE.—The application  
4 of this subparagraph may result in such  
5 annual update being less than 0.0 for a  
6 rate year, and may result in payment rates  
7 under the system described in paragraph  
8 (1) for a rate year being less than such  
9 payment rates for the preceding rate year.

10 “(B) NONCUMULATIVE APPLICATION.—  
11 Any reduction under subparagraph (A) shall  
12 apply only with respect to the rate year involved  
13 and the Secretary shall not take into account  
14 such reduction in computing the payment  
15 amount under the system described in para-  
16 graph (1) for a subsequent rate year.

17 “(C) SUBMISSION OF QUALITY DATA.—For  
18 rate year 2014 and each subsequent rate year,  
19 each psychiatric hospital and psychiatric unit  
20 shall submit to the Secretary data on quality  
21 measures specified under subparagraph (D).  
22 Such data shall be submitted in a form and  
23 manner, and at a time, specified by the Sec-  
24 retary for purposes of this subparagraph.

25 “(D) QUALITY MEASURES.—

1                   “(i) IN GENERAL.—Subject to clause  
2                   (ii), any measure specified by the Secretary  
3                   under this subparagraph must have been  
4                   endorsed by the entity with a contract  
5                   under section 1890(a).

6                   “(ii) EXCEPTION.—In the case of a  
7                   specified area or medical topic determined  
8                   appropriate by the Secretary for which a  
9                   feasible and practical measure has not  
10                  been endorsed by the entity with a contract  
11                  under section 1890(a), the Secretary may  
12                  specify a measure that is not so endorsed  
13                  as long as due consideration is given to  
14                  measures that have been endorsed or  
15                  adopted by a consensus organization iden-  
16                  tified by the Secretary.

17                  “(iii) TIME FRAME.—Not later than  
18                  October 1, 2012, the Secretary shall pub-  
19                  lish the measures selected under this sub-  
20                  paragraph that will be applicable with re-  
21                  spect to rate year 2014.

22                  “(E) PUBLIC AVAILABILITY OF DATA SUB-  
23                  MITTED.—The Secretary shall establish proce-  
24                  dures for making data submitted under sub-  
25                  paragraph (C) available to the public. Such pro-

1           cedures shall ensure that a psychiatric hospital  
2           and a psychiatric unit has the opportunity to  
3           review the data that is to be made public with  
4           respect to the hospital or unit prior to such  
5           data being made public. The Secretary shall re-  
6           port quality measures that relate to services  
7           furnished in inpatient settings in psychiatric  
8           hospitals and psychiatric units on the Internet  
9           website of the Centers for Medicare & Medicaid  
10          Services.”.

11          (b)           CONFORMING            AMENDMENT.—Section  
12 1890(b)(7)(B)(i)(I) of the Social Security Act, as added  
13 by section 3014, is amended by inserting  
14 “1886(s)(4)(D),” after “1886(o)(2),”.

15 **SEC. 10323. MEDICARE COVERAGE FOR INDIVIDUALS EX-**  
16 **POSED TO ENVIRONMENTAL HEALTH HAZ-**  
17 **ARDS.**

18          (a) IN GENERAL.—Title XVIII of the Social Security  
19 Act (42 U.S.C. 1395 et seq.) is amended by inserting after  
20 section 1881 the following new section:

21 **“SEC. 1881A. MEDICARE COVERAGE FOR INDIVIDUALS EX-**  
22 **POSED TO ENVIRONMENTAL HEALTH HAZ-**  
23 **ARDS.**

24          “(a) DEEMING OF INDIVIDUALS AS ELIGIBLE FOR  
25 MEDICARE BENEFITS.—

1           “(1) IN GENERAL.—For purposes of eligibility  
2 for benefits under this title, an individual deter-  
3 mined under subsection (c) to be an environmental  
4 exposure affected individual described in subsection  
5 (e)(2) shall be deemed to meet the conditions speci-  
6 fied in section 226(a).

7           “(2) DISCRETIONARY DEEMING.—For purposes  
8 of eligibility for benefits under this title, the Sec-  
9 retary may deem an individual determined under  
10 subsection (c) to be an environmental exposure af-  
11 fected individual described in subsection (e)(3) to  
12 meet the conditions specified in section 226(a).

13           “(3) EFFECTIVE DATE OF COVERAGE.—An In-  
14 dividual who is deemed eligible for benefits under  
15 this title under paragraph (1) or (2) shall be—

16                   “(A) entitled to benefits under the pro-  
17 gram under Part A as of the date of such  
18 deeming; and

19                   “(B) eligible to enroll in the program  
20 under Part B beginning with the month in  
21 which such deeming occurs.

22           “(b) PILOT PROGRAM FOR CARE OF CERTAIN INDI-  
23 VIDUALS RESIDING IN EMERGENCY DECLARATION  
24 AREAS.—

25                   “(1) PROGRAM; PURPOSE.—

1           “(A) PRIMARY PILOT PROGRAM.—The Sec-  
2           retary shall establish a pilot program in accord-  
3           ance with this subsection to provide innovative  
4           approaches to furnishing comprehensive, coordi-  
5           nated, and cost-effective care under this title to  
6           individuals described in paragraph (2)(A).

7           “(B) OPTIONAL PILOT PROGRAMS.—The  
8           Secretary may establish a separate pilot pro-  
9           gram, in accordance with this subsection, with  
10          respect to each geographic area subject to an  
11          emergency declaration (other than the declara-  
12          tion of June 17, 2009), in order to furnish such  
13          comprehensive, coordinated and cost-effective  
14          care to individuals described in subparagraph  
15          (2)(B) who reside in each such area.

16          “(2) INDIVIDUAL DESCRIBED.—For purposes of  
17          paragraph (1), an individual described in this para-  
18          graph is an individual who enrolls in part B, submits  
19          to the Secretary an application to participate in the  
20          applicable pilot program under this subsection,  
21          and—

22                 “(A) is an environmental exposure affected  
23                 individual described in subsection (e)(2) who re-  
24                 sides in or around the geographic area subject

1 to an emergency declaration made as of June  
2 17, 2009; or

3 “(B) is an environmental exposure affected  
4 individual described in subsection (e)(3) who—

5 “(i) is deemed under subsection  
6 (a)(2); and

7 “(ii) meets such other criteria or con-  
8 ditions for participation in a pilot program  
9 under paragraph (1)(B) as the Secretary  
10 specifies.

11 “(3) FLEXIBLE BENEFITS AND SERVICES.—A  
12 pilot program under this subsection may provide for  
13 the furnishing of benefits, items, or services not oth-  
14 erwise covered or authorized under this title, if the  
15 Secretary determines that furnishing such benefits,  
16 items, or services will further the purposes of such  
17 pilot program (as described in paragraph (1)).

18 “(4) INNOVATIVE REIMBURSEMENT METH-  
19 ODOLOGIES.—For purposes of the pilot program  
20 under this subsection, the Secretary—

21 “(A) shall develop and implement appro-  
22 priate methodologies to reimburse providers for  
23 furnishing benefits, items, or services for which  
24 payment is not otherwise covered or authorized  
25 under this title, if such benefits, items, or serv-

1           ices are furnished pursuant to paragraph (3);  
2           and

3                   “(B) may develop and implement innova-  
4           tive approaches to reimbursing providers for  
5           any benefits, items, or services furnished under  
6           this subsection.

7           “(5) LIMITATION.—Consistent with section  
8           1862(b), no payment shall be made under the pilot  
9           program under this subsection with respect to bene-  
10          fits, items, or services furnished to an environmental  
11          exposure affected individual (as defined in sub-  
12          section (e)) to the extent that such individual is eli-  
13          gible to receive such benefits, items, or services  
14          through any other public or private benefits plan or  
15          legal agreement.

16           “(6) WAIVER AUTHORITY.—The Secretary may  
17          waive such provisions of this title and title XI as are  
18          necessary to carry out pilot programs under this  
19          subsection.

20           “(7) FUNDING.—For purposes of carrying out  
21          pilot programs under this subsection, the Secretary  
22          shall provide for the transfer, from the Federal Hos-  
23          pital Insurance Trust Fund under section 1817 and  
24          the Federal Supplementary Medical Insurance Trust  
25          Fund under section 1841, in such proportion as the

1 Secretary determines appropriate, of such sums as  
2 the Secretary determines necessary, to the Centers  
3 for Medicare & Medicaid Services Program Manage-  
4 ment Account.

5 “(8) WAIVER OF BUDGET NEUTRALITY.—The  
6 Secretary shall not require that pilot programs  
7 under this subsection be budget neutral with respect  
8 to expenditures under this title.

9 “(c) DETERMINATIONS.—

10 “(1) BY THE COMMISSIONER OF SOCIAL SECU-  
11 RITY.—For purposes of this section, the Commis-  
12 sioner of Social Security, in consultation with the  
13 Secretary, and using the cost allocation method pre-  
14 scribed in section 201(g), shall determine whether  
15 individuals are environmental exposure affected indi-  
16 viduals.

17 “(2) BY THE SECRETARY.—The Secretary shall  
18 determine eligibility for pilot programs under sub-  
19 section (b).

20 “(d) EMERGENCY DECLARATION DEFINED.—For  
21 purposes of this section, the term ‘emergency declaration’  
22 means a declaration of a public health emergency under  
23 section 104(a) of the Comprehensive Environmental Re-  
24 sponse, Compensation, and Liability Act of 1980.

1       “(e) ENVIRONMENTAL EXPOSURE AFFECTED INDI-  
2 VIDUAL DEFINED.—

3           “(1) IN GENERAL.—For purposes of this sec-  
4 tion, the term ‘environmental exposure affected indi-  
5 vidual’ means—

6           “(A) an individual described in paragraph  
7 (2); and

8           “(B) an individual described in paragraph  
9 (3).

10       “(2) INDIVIDUAL DESCRIBED.—

11           “(A) IN GENERAL.—An individual de-  
12 scribed in this paragraph is any individual  
13 who—

14           “(i) is diagnosed with 1 or more con-  
15 ditions described in subparagraph (B);

16           “(ii) as demonstrated in such manner  
17 as the Secretary determines appropriate,  
18 has been present for an aggregate total of  
19 6 months in the geographic area subject to  
20 an emergency declaration specified in sub-  
21 section (b)(2)(A), during a period ending—

22           “(I) not less than 10 years prior  
23 to such diagnosis; and

24           “(II) prior to the implementation  
25 of all the remedial and removal ac-

1                   tions specified in the Record of Deci-  
2                   sion for Operating Unit 4 and the  
3                   Record of Decision for Operating Unit  
4                   7;

5                   “(iii) files an application for benefits  
6                   under this title (or has an application filed  
7                   on behalf of the individual), including pur-  
8                   suant to this section; and

9                   “(iv) is determined under this section  
10                  to meet the criteria in this subparagraph.

11                  “(B) CONDITIONS DESCRIBED.—For pur-  
12                  poses of subparagraph (A), the following condi-  
13                  tions are described in this subparagraph:

14                  “(i) Asbestosis, pleural thickening, or  
15                  pleural plaques as established by—

16                         “(I) interpretation by a ‘B Read-  
17                         er’ qualified physician of a plain chest  
18                         x-ray or interpretation of a computed  
19                         tomographic radiograph of the chest  
20                         by a qualified physician, as deter-  
21                         mined by the Secretary; or

22                         “(II) such other diagnostic stand-  
23                         ards as the Secretary specifies,

24                  except that this clause shall not apply to  
25                  pleural thickening or pleural plaques unless

1           there are symptoms or conditions requiring  
2           medical treatment as a result of these di-  
3           agnoses.

4           “(ii) Mesothelioma, or malignancies of  
5           the lung, colon, rectum, larynx, stomach,  
6           esophagus, pharynx, or ovary, as estab-  
7           lished by—

8                   “(I) pathologic examination of bi-  
9                   opsy tissue;

10                   “(II)           cytology           from  
11                   bronchioalveolar lavage; or

12                   “(III) such other diagnostic  
13                   standards as the Secretary specifies.

14           “(iii) Any other diagnosis which the  
15           Secretary, in consultation with the Com-  
16           missioner of Social Security, determines is  
17           an asbestos-related medical condition, as  
18           established by such diagnostic standards as  
19           the Secretary specifies.

20           “(3) OTHER INDIVIDUAL DESCRIBED.—An indi-  
21           vidual described in this paragraph is any individual  
22           who—

23                   “(A) is not an individual described in para-  
24                   graph (2);

1           “(B) is diagnosed with a medical condition  
2           caused by the exposure of the individual to a  
3           public health hazard to which an emergency  
4           declaration applies, based on such medical con-  
5           ditions, diagnostic standards, and other criteria  
6           as the Secretary specifies;

7           “(C) as demonstrated in such manner as  
8           the Secretary determines appropriate, has been  
9           present for an aggregate total of 6 months in  
10          the geographic area subject to the emergency  
11          declaration involved, during a period deter-  
12          mined appropriate by the Secretary;

13          “(D) files an application for benefits under  
14          this title (or has an application filed on behalf  
15          of the individual), including pursuant to this  
16          section; and

17          “(E) is determined under this section to  
18          meet the criteria in this paragraph.”.

19          (b) PROGRAM FOR EARLY DETECTION OF CERTAIN  
20          MEDICAL CONDITIONS RELATED TO ENVIRONMENTAL  
21          HEALTH HAZARDS.—Title XX of the Social Security Act  
22          (42 U.S.C. 1397 et seq.), as amended by section 5507,  
23          is amended by adding at the end the following:

1 **“SEC. 2009. PROGRAM FOR EARLY DETECTION OF CERTAIN**  
2 **MEDICAL CONDITIONS RELATED TO ENVI-**  
3 **RONMENTAL HEALTH HAZARDS.**

4 “(a) PROGRAM ESTABLISHMENT.—The Secretary  
5 shall establish a program in accordance with this section  
6 to make competitive grants to eligible entities specified in  
7 subsection (b) for the purpose of—

8 “(1) screening at-risk individuals (as defined in  
9 subsection (c)(1)) for environmental health condi-  
10 tions (as defined in subsection (c)(3)); and

11 “(2) developing and disseminating public infor-  
12 mation and education concerning—

13 “(A) the availability of screening under the  
14 program under this section;

15 “(B) the detection, prevention, and treat-  
16 ment of environmental health conditions; and

17 “(C) the availability of Medicare benefits  
18 for certain individuals diagnosed with environ-  
19 mental health conditions under section 1881A.

20 “(b) ELIGIBLE ENTITIES.—

21 “(1) IN GENERAL.—For purposes of this sec-  
22 tion, an eligible entity is an entity described in para-  
23 graph (2) which submits an application to the Sec-  
24 retary in such form and manner, and containing  
25 such information and assurances, as the Secretary  
26 determines appropriate.

1           “(2) TYPES OF ELIGIBLE ENTITIES.—The enti-  
2           ties described in this paragraph are the following:

3                   “(A) A hospital or community health cen-  
4           ter.

5                   “(B) A Federally qualified health center.

6                   “(C) A facility of the Indian Health Serv-  
7           ice.

8                   “(D) A National Cancer Institute-des-  
9           ignated cancer center.

10                  “(E) An agency of any State or local gov-  
11           ernment.

12                  “(F) A nonprofit organization.

13                  “(G) Any other entity the Secretary deter-  
14           mines appropriate.

15           “(c) DEFINITIONS.—In this section:

16                   “(1) AT-RISK INDIVIDUAL.—The term ‘at-risk  
17           individual’ means an individual who—

18                           “(A)(i) as demonstrated in such manner as  
19           the Secretary determines appropriate, has been  
20           present for an aggregate total of 6 months in  
21           the geographic area subject to an emergency  
22           declaration specified under paragraph (2), dur-  
23           ing a period ending—

1                   “(I) not less than 10 years prior to  
2                   the date of such individual’s application  
3                   under subparagraph (B); and

4                   “(II) prior to the implementation of  
5                   all the remedial and removal actions speci-  
6                   fied in the Record of Decision for Oper-  
7                   ating Unit 4 and the Record of Decision  
8                   for Operating Unit 7; or

9                   “(ii) meets such other criteria as the Sec-  
10                  retary determines appropriate considering the  
11                  type of environmental health condition at issue;  
12                  and

13                  “(B) has submitted an application (or has  
14                  an application submitted on the individual’s be-  
15                  half), to an eligible entity receiving a grant  
16                  under this section, for screening under the pro-  
17                  gram under this section.

18                  “(2) EMERGENCY DECLARATION.—The term  
19                  ‘emergency declaration’ means a declaration of a  
20                  public health emergency under section 104(a) of the  
21                  Comprehensive Environmental Response, Compensa-  
22                  tion, and Liability Act of 1980.

23                  “(3) ENVIRONMENTAL HEALTH CONDITION.—  
24                  The term ‘environmental health condition’ means—

1           “(A) asbestosis, pleural thickening, or  
2 pleural plaques, as established by—

3           “(i) interpretation by a ‘B Reader’  
4 qualified physician of a plain chest x-ray or  
5 interpretation of a computed tomographic  
6 radiograph of the chest by a qualified phy-  
7 sician, as determined by the Secretary; or

8           “(ii) such other diagnostic standards  
9 as the Secretary specifies;

10          “(B) mesothelioma, or malignancies of the  
11 lung, colon, rectum, larynx, stomach, esoph-  
12 agus, pharynx, or ovary, as established by—

13          “(i) pathologic examination of biopsy  
14 tissue;

15          “(ii) cytology from bronchioalveolar  
16 lavage; or

17          “(iii) such other diagnostic standards  
18 as the Secretary specifies; and

19          “(C) any other medical condition which the  
20 Secretary determines is caused by exposure to  
21 a hazardous substance or pollutant or contami-  
22 nant at a Superfund site to which an emergency  
23 declaration applies, based on such criteria and  
24 as established by such diagnostic standards as  
25 the Secretary specifies.

1           “(4) HAZARDOUS SUBSTANCE; POLLUTANT;  
2           CONTAMINANT.—The terms ‘hazardous substance’,  
3           ‘pollutant’, and ‘contaminant’ have the meanings  
4           given those terms in section 101 of the Comprehen-  
5           sive Environmental Response, Compensation, and  
6           Liability Act of 1980 (42 U.S.C. 9601).

7           “(5) SUPERFUND SITE.—The term ‘Superfund  
8           site’ means a site included on the National Priorities  
9           List developed by the President in accordance with  
10          section 105(a)(8)(B) of the Comprehensive Environ-  
11          mental Response, Compensation, and Liability Act  
12          of 1980 (42 U.S.C. 9605(a)(8)(B)).

13          “(d) HEALTH COVERAGE UNAFFECTED.—Nothing in  
14          this section shall be construed to affect any coverage obli-  
15          gation of a governmental or private health plan or pro-  
16          gram relating to an at-risk individual.

17          “(e) FUNDING.—

18                 “(1) IN GENERAL.—Out of any funds in the  
19                 Treasury not otherwise appropriated, there are ap-  
20                 propriated to the Secretary, to carry out the pro-  
21                 gram under this section—

22                         “(A) \$23,000,000 for the period of fiscal  
23                         years 2010 through 2014; and

24                         “(B) \$20,000,000 for each 5-fiscal year  
25                         period thereafter.

1           “(2) AVAILABILITY.—Funds appropriated  
2 under paragraph (1) shall remain available until ex-  
3 pended.

4           “(f) NONAPPLICATION.—

5           “(1) IN GENERAL.—Except as provided in para-  
6 graph (2), the preceding sections of this title shall  
7 not apply to grants awarded under this section.

8           “(2) LIMITATIONS ON USE OF GRANTS.—Sec-  
9 tion 2005(a) shall apply to a grant awarded under  
10 this section to the same extent and in the same  
11 manner as such section applies to payments to  
12 States under this title, except that paragraph (4) of  
13 such section shall not be construed to prohibit grant-  
14 ees from conducting screening for environmental  
15 health conditions as authorized under this section.”.

16 **SEC. 10324. PROTECTIONS FOR FRONTIER STATES.**

17           (a) FLOOR ON AREA WAGE INDEX FOR HOSPITALS  
18 IN FRONTIER STATES.—

19           (1) IN GENERAL.—Section 1886(d)(3)(E) of  
20 the Social Security Act (42 U.S.C.  
21 1395ww(d)(3)(E)) is amended—

22                   (A) in clause (i), by striking “clause (ii)”  
23 and inserting “clause (ii) or (iii)”; and

24                   (B) by adding at the end the following new  
25 clause:

1                   “(iii) FLOOR ON AREA WAGE INDEX  
2 FOR HOSPITALS IN FRONTIER STATES.—

3                   “(I) IN GENERAL.—Subject to  
4 subclause (IV), for discharges occur-  
5 ring on or after October 1, 2010, the  
6 area wage index applicable under this  
7 subparagraph to any hospital which is  
8 located in a frontier State (as defined  
9 in subclause (II)) may not be less  
10 than 1.00.

11                   “(II) FRONTIER STATE DE-  
12 FINED.—In this clause, the term  
13 ‘frontier State’ means a State in  
14 which at least 50 percent of the coun-  
15 ties in the State are frontier counties.

16                   “(III) FRONTIER COUNTY DE-  
17 FINED.—In this clause, the term  
18 ‘frontier county’ means a county in  
19 which the population per square mile  
20 is less than 6.

21                   “(IV) LIMITATION.—This clause  
22 shall not apply to any hospital located  
23 in a State that receives a non-labor  
24 related share adjustment under para-  
25 graph (5)(H).”.

1           (2) WAIVING BUDGET NEUTRALITY.—Section  
2           1886(d)(3)(E) of the Social Security Act (42 U.S.C.  
3           1395ww(d)(3)(E)), as amended by subsection (a), is  
4           amended in the third sentence by inserting “and the  
5           amendments made by section 10324(a)(1) of the Pa-  
6           tient Protection and Affordable Care Act” after  
7           “2003”.

8           (b) FLOOR ON AREA WAGE ADJUSTMENT FACTOR  
9           FOR HOSPITAL OUTPATIENT DEPARTMENT SERVICES IN  
10          FRONTIER STATES.—Section 1833(t) of the Social Secu-  
11          rity Act (42 U.S.C. 1395l(t)), as amended by section  
12          3138, is amended—

13           (1) in paragraph (2)(D), by striking “the Sec-  
14          retary” and inserting “subject to paragraph (19),  
15          the Secretary”; and

16           (2) by adding at the end the following new  
17          paragraph:

18           “(19) FLOOR ON AREA WAGE ADJUSTMENT  
19          FACTOR FOR HOSPITAL OUTPATIENT DEPARTMENT  
20          SERVICES IN FRONTIER STATES.—

21           “(A) IN GENERAL.—Subject to subpara-  
22          graph (B), with respect to covered OPD serv-  
23          ices furnished on or after January 1, 2011, the  
24          area wage adjustment factor applicable under  
25          the payment system established under this sub-

1 section to any hospital outpatient department  
2 which is located in a frontier State (as defined  
3 in section 1886(d)(3)(E)(iii)(II)) may not be  
4 less than 1.00. The preceding sentence shall not  
5 be applied in a budget neutral manner.

6 “(B) LIMITATION.—This paragraph shall  
7 not apply to any hospital outpatient department  
8 located in a State that receives a non-labor re-  
9 lated share adjustment under section  
10 1886(d)(5)(H).”.

11 (c) FLOOR FOR PRACTICE EXPENSE INDEX FOR  
12 PHYSICIANS’ SERVICES FURNISHED IN FRONTIER  
13 STATES.—Section 1848(e)(1) of the Social Security Act  
14 (42 U.S.C. 1395w-4(e)(1)), as amended by section 3102,  
15 is amended—

16 (1) in subparagraph (A), by striking “and (H)”  
17 and inserting “(H), and (I)”; and

18 (2) by adding at the end the following new sub-  
19 paragraph:

20 “(I) FLOOR FOR PRACTICE EXPENSE  
21 INDEX FOR SERVICES FURNISHED IN FRONTIER  
22 STATES.—

23 “(i) IN GENERAL.—Subject to clause  
24 (ii), for purposes of payment for services  
25 furnished in a frontier State (as defined in

1 section 1886(d)(3)(E)(iii)(II)) on or after  
2 January 1, 2011, after calculating the  
3 practice expense index in subparagraph  
4 (A)(i), the Secretary shall increase any  
5 such index to 1.00 if such index would oth-  
6 erwise be less than 1.00. The preceding  
7 sentence shall not be applied in a budget  
8 neutral manner.

9 “(ii) LIMITATION.—This subpara-  
10 graph shall not apply to services furnished  
11 in a State that receives a non-labor related  
12 share adjustment under section  
13 1886(d)(5)(H).”.

14 **SEC. 10325. REVISION TO SKILLED NURSING FACILITY PRO-**  
15 **SPECTIVE PAYMENT SYSTEM.**

16 (a) TEMPORARY DELAY OF RUG-IV.—Notwith-  
17 standing any other provision of law, the Secretary of  
18 Health and Human Services shall not, prior to October  
19 1, 2011, implement Version 4 of the Resource Utilization  
20 Groups (in this subsection referred to as “RUG-IV”) pub-  
21 lished in the Federal Register on August 11, 2009, enti-  
22 tled “Prospective Payment System and Consolidated Bill-  
23 ing for Skilled Nursing Facilities for FY 2010; Minimum  
24 Data Set, Version 3.0 for Skilled Nursing Facilities and  
25 Medicaid Nursing Facilities” (74 Fed. Reg. 40288). Be-

1 ginning on October 1, 2010, the Secretary of Health and  
2 Human Services shall implement the change specific to  
3 therapy furnished on a concurrent basis that is a compo-  
4 nent of RUG-IV and changes to the lookback period to  
5 ensure that only those services furnished after admission  
6 to a skilled nursing facility are used as factors in deter-  
7 mining a case mix classification under the skilled nursing  
8 facility prospective payment system under section 1888(e)  
9 of the Social Security Act (42 U.S.C. 1395yy(e)).

10 (b) CONSTRUCTION.—Nothing in this section shall be  
11 interpreted as delaying the implementation of Version 3.0  
12 of the Minimum Data Sets (MDS 3.0) beyond the planned  
13 implementation date of October 1, 2010.

14 **SEC. 10326. PILOT TESTING PAY-FOR-PERFORMANCE PRO-**  
15 **GRAMS FOR CERTAIN MEDICARE PROVIDERS.**

16 (a) IN GENERAL.—Not later than January 1, 2016,  
17 the Secretary of Health and Human Services (in this sec-  
18 tion referred to as the “Secretary”) shall, for each pro-  
19 vider described in subsection (b), conduct a separate pilot  
20 program under title XVIII of the Social Security Act to  
21 test the implementation of a value-based purchasing pro-  
22 gram for payments under such title for the provider.

23 (b) PROVIDERS DESCRIBED.—The providers de-  
24 scribed in this paragraph are the following:

1           (1) Psychiatric hospitals (as described in clause  
2           (i) of section 1886(d)(1)(B) of such Act (42 U.S.C.  
3           1395ww(d)(1)(B))) and psychiatric units (as de-  
4           scribed in the matter following clause (v) of such  
5           section).

6           (2) Long-term care hospitals (as described in  
7           clause (iv) of such section).

8           (3) Rehabilitation hospitals (as described in  
9           clause (ii) of such section).

10          (4) PPS-exempt cancer hospitals (as described  
11          in clause (v) of such section).

12          (5) Hospice programs (as defined in section  
13          1861(dd)(2) of such Act (42 U.S.C. 1395x(dd)(2))).

14          (c) WAIVER AUTHORITY.—The Secretary may waive  
15 such requirements of titles XI and XVIII of the Social  
16 Security Act as may be necessary solely for purposes of  
17 carrying out the pilot programs under this section.

18          (d) NO ADDITIONAL PROGRAM EXPENDITURES.—  
19 Payments under this section under the separate pilot pro-  
20 gram for value based purchasing (as described in sub-  
21 section (a)) for each provider type described in paragraphs  
22 (1) through (5) of subsection (b) for applicable items and  
23 services under title XVIII of the Social Security Act for  
24 a year shall be established in a manner that does not re-  
25 sult in spending more under each such value based pur-

1 chasing program for such year than would otherwise be  
2 expended for such provider type for such year if the pilot  
3 program were not implemented, as estimated by the Sec-  
4 retary.

5 (e) EXPANSION OF PILOT PROGRAM.—The Secretary  
6 may, at any point after January 1, 2018, expand the dura-  
7 tion and scope of a pilot program conducted under this  
8 subsection, to the extent determined appropriate by the  
9 Secretary, if—

10 (1) the Secretary determines that such expan-  
11 sion is expected to—

12 (A) reduce spending under title XVIII of  
13 the Social Security Act without reducing the  
14 quality of care; or

15 (B) improve the quality of care and reduce  
16 spending;

17 (2) the Chief Actuary of the Centers for Medi-  
18 care & Medicaid Services certifies that such expan-  
19 sion would reduce program spending under such title  
20 XVIII; and

21 (3) the Secretary determines that such expan-  
22 sion would not deny or limit the coverage or provi-  
23 sion of benefits under such title XIII for Medicare  
24 beneficiaries.

1 **SEC. 10327. IMPROVEMENTS TO THE PHYSICIAN QUALITY**  
2 **REPORTING SYSTEM.**

3 (a) IN GENERAL.—Section 1848(m) of the Social Se-  
4 curity Act (42 U.S.C. 1395w-4(m)) is amended by adding  
5 at the end the following new paragraph:

6 “(7) ADDITIONAL INCENTIVE PAYMENT.—

7 “(A) IN GENERAL.—For 2011 through  
8 2014, if an eligible professional meets the re-  
9 quirements described in subparagraph (B), the  
10 applicable quality percent for such year, as de-  
11 scribed in clauses (iii) and (iv) of paragraph  
12 (1)(B), shall be increased by 0.5 percentage  
13 points.

14 “(B) REQUIREMENTS DESCRIBED.—In  
15 order to qualify for the additional incentive pay-  
16 ment described in subparagraph (A), an eligible  
17 professional shall meet the following require-  
18 ments:

19 “(i) The eligible professional shall—

20 “(I) satisfactorily submit data on  
21 quality measures for purposes of para-  
22 graph (1) for a year; and

23 “(II) have such data submitted  
24 on their behalf through a Maintenance  
25 of Certification Program (as defined  
26 in subparagraph (C)(i)) that meets—

1                   “(aa) the criteria for a reg-  
2                   istry (as described in subsection  
3                   (k)(4)); or

4                   “(bb) an alternative form  
5                   and manner determined appro-  
6                   priate by the Secretary.

7                   “(ii) The eligible professional, more  
8                   frequently than is required to qualify for or  
9                   maintain board certification status—

10                   “(I) participates in such a Main-  
11                   tenance of Certification program for a  
12                   year; and

13                   “(II) successfully completes a  
14                   qualified Maintenance of Certification  
15                   Program practice assessment (as de-  
16                   fined in subparagraph (C)(ii)) for  
17                   such year.

18                   “(iii) A Maintenance of Certification  
19                   program submits to the Secretary, on be-  
20                   half of the eligible professional, informa-  
21                   tion—

22                   “(I) in a form and manner speci-  
23                   fied by the Secretary, that the eligible  
24                   professional has successfully met the  
25                   requirements of clause (ii) (which may

1 be in the form of a structural meas-  
2 ure);

3 “(II) if requested by the Sec-  
4 retary, on the survey of patient expe-  
5 rience with care (as described in sub-  
6 paragraph (C)(ii)(II)); and

7 “(III) as the Secretary may re-  
8 quire, on the methods, measures, and  
9 data used under the Maintenance of  
10 Certification Program and the quali-  
11 fied Maintenance of Certification Pro-  
12 gram practice assessment.

13 “(C) DEFINITIONS.—For purposes of this  
14 paragraph:

15 “(i) The term ‘Maintenance of Certifi-  
16 cation Program’ means a continuous as-  
17 sessment program, such as qualified Amer-  
18 ican Board of Medical Specialties Mainte-  
19 nance of Certification program or an  
20 equivalent program (as determined by the  
21 Secretary), that advances quality and the  
22 lifelong learning and self-assessment of  
23 board certified specialty physicians by fo-  
24 cusing on the competencies of patient care,  
25 medical knowledge, practice-based learning,

1 interpersonal and communication skills and  
2 professionalism. Such a program shall in-  
3 clude the following:

4 “(I) The program requires the  
5 physician to maintain a valid, unre-  
6 stricted medical license in the United  
7 States.

8 “(II) The program requires a  
9 physician to participate in educational  
10 and self-assessment programs that re-  
11 quire an assessment of what was  
12 learned.

13 “(III) The program requires a  
14 physician to demonstrate, through a  
15 formalized, secure examination, that  
16 the physician has the fundamental di-  
17 agnostic skills, medical knowledge,  
18 and clinical judgment to provide qual-  
19 ity care in their respective specialty.

20 “(IV) The program requires suc-  
21 cessful completion of a qualified Main-  
22 tenance of Certification Program  
23 practice assessment as described in  
24 clause (ii).

1                   “(ii) The term ‘qualified Maintenance  
2                   of Certification Program practice assess-  
3                   ment’ means an assessment of a physi-  
4                   cian’s practice that—

5                                 “(I) includes an initial assess-  
6                                 ment of an eligible professional’s prac-  
7                                 tice that is designed to demonstrate  
8                                 the physician’s use of evidence-based  
9                                 medicine;

10                                “(II) includes a survey of patient  
11                                experience with care; and

12                                “(III) requires a physician to im-  
13                                plement a quality improvement inter-  
14                                vention to address a practice weak-  
15                                ness identified in the initial assess-  
16                                ment under subclause (I) and then to  
17                                remeasure to assess performance im-  
18                                provement after such intervention.”.

19           (b) **AUTHORITY.**—Section 3002(c) of this Act is  
20 amended by adding at the end the following new para-  
21 graph:

22                                “(3) **AUTHORITY.**—For years after 2014, if the  
23                                Secretary of Health and Human Services determines  
24                                it to be appropriate, the Secretary may incorporate  
25                                participation in a Maintenance of Certification Pro-

1       gram and successful completion of a qualified Main-  
2       tenance of Certification Program practice assess-  
3       ment into the composite of measures of quality of  
4       care furnished pursuant to the physician fee sched-  
5       ule payment modifier, as described in section  
6       1848(p)(2) of the Social Security Act (42 U.S.C.  
7       1395w-4(p)(2)).”.

8       (c) ELIMINATION OF MA REGIONAL PLAN STA-  
9       BILIZATION FUND.—

10           (1) IN GENERAL.—Section 1858 of the Social  
11       Security Act (42 U.S.C. 1395w-27a) is amended by  
12       striking subsection (e).

13           (2) TRANSITION.—Any amount contained in the  
14       MA Regional Plan Stabilization Fund as of the date  
15       of the enactment of this Act shall be transferred to  
16       the Federal Supplementary Medical Insurance Trust  
17       Fund.

18       **SEC. 10328. IMPROVEMENT IN PART D MEDICATION THER-**

19                           **APY MANAGEMENT (MTM) PROGRAMS.**

20           (a) IN GENERAL.—Section 1860D-4(c)(2) of the So-  
21       cial Security Act (42 U.S.C. 1395w-104(c)(2)) is amend-  
22       ed—

23           (1) by redesignating subparagraphs (C), (D),  
24       and (E) as subparagraphs (E), (F), and (G), respec-  
25       tively; and



1 scriber to the extent necessary and  
2 practicable; and

3 “(II) shall include providing the  
4 individual with a written or printed  
5 summary of the results of the review.

6 The Secretary, in consultation with rel-  
7 evant stakeholders, shall develop a stand-  
8 ardized format for the action plan under  
9 subclause (I) and the summary under sub-  
10 clause (II).

11 “(ii) Follow-up interventions as war-  
12 ranted based on the findings of the annual  
13 medication review or the targeted medica-  
14 tion enrollment and which may be provided  
15 person-to-person or using telehealth tech-  
16 nologies (as defined by the Secretary).

17 “(D) ASSESSMENT.—The prescription  
18 drug plan sponsor shall have in place a process  
19 to assess, at least on a quarterly basis, the  
20 medication use of individuals who are at risk  
21 but not enrolled in the medication therapy man-  
22 agement program, including individuals who  
23 have experienced a transition in care, if the pre-  
24 scription drug plan sponsor has access to that  
25 information.

1           “(E) AUTOMATIC ENROLLMENT WITH  
2 ABILITY TO OPT-OUT.—The prescription drug  
3 plan sponsor shall have in place a process to—

4                   “(i) subject to clause (ii), automati-  
5 cally enroll targeted beneficiaries described  
6 in subparagraph (A)(ii), including bene-  
7 ficiaries identified under subparagraph  
8 (D), in the medication therapy manage-  
9 ment program required under this sub-  
10 section; and

11                   “(ii) permit such beneficiaries to opt-  
12 out of enrollment in such program.”.

13       (b) RULE OF CONSTRUCTION.—Nothing in this sec-  
14 tion shall limit the authority of the Secretary of Health  
15 and Human Services to modify or broaden requirements  
16 for a medication therapy management program under part  
17 D of title XVIII of the Social Security Act or to study  
18 new models for medication therapy management through  
19 the Center for Medicare and Medicaid Innovation under  
20 section 1115A of such Act, as added by section 3021.

21 **SEC. 10329. DEVELOPING METHODOLOGY TO ASSESS**  
22 **HEALTH PLAN VALUE.**

23       (a) DEVELOPMENT.—The Secretary of Health and  
24 Human Services (referred to in this section as the “Sec-  
25 retary”), in consultation with relevant stakeholders includ-

1 ing health insurance issuers, health care consumers, em-  
2 ployers, health care providers, and other entities deter-  
3 mined appropriate by the Secretary, shall develop a meth-  
4 odology to measure health plan value. Such methodology  
5 shall take into consideration, where applicable—

6 (1) the overall cost to enrollees under the plan;

7 (2) the quality of the care provided for under  
8 the plan;

9 (3) the efficiency of the plan in providing care;

10 (4) the relative risk of the plan's enrollees as  
11 compared to other plans;

12 (5) the actuarial value or other comparative  
13 measure of the benefits covered under the plan; and

14 (6) other factors determined relevant by the  
15 Secretary.

16 (b) REPORT.—Not later than 18 months after the  
17 date of enactment of this Act, the Secretary shall submit  
18 to Congress a report concerning the methodology devel-  
19 oped under subsection (a).

20 **SEC. 10330. MODERNIZING COMPUTER AND DATA SYSTEMS**  
21 **OF THE CENTERS FOR MEDICARE & MED-**  
22 **ICAID SERVICES TO SUPPORT IMPROVE-**  
23 **MENTS IN CARE DELIVERY.**

24 (a) IN GENERAL.—The Secretary of Health and  
25 Human Services (in this section referred to as the “Sec-

1 retary”) shall develop a plan (and detailed budget for the  
2 resources needed to implement such plan) to modernize  
3 the computer and data systems of the Centers for Medi-  
4 care & Medicaid Services (in this section referred to as  
5 “CMS”).

6 (b) CONSIDERATIONS.—In developing the plan, the  
7 Secretary shall consider how such modernized computer  
8 system could—

9 (1) in accordance with the regulations promul-  
10 gated under section 264(c) of the Health Insurance  
11 Portability and Accountability Act of 1996, make  
12 available data in a reliable and timely manner to  
13 providers of services and suppliers to support their  
14 efforts to better manage and coordinate care fur-  
15 nished to beneficiaries of CMS programs; and

16 (2) support consistent evaluations of payment  
17 and delivery system reforms under CMS programs.

18 (c) POSTING OF PLAN.—By not later than 9 months  
19 after the date of the enactment of this Act, the Secretary  
20 shall post on the website of the Centers for Medicare &  
21 Medicaid Services the plan described in subsection (a).

22 **SEC. 10331. PUBLIC REPORTING OF PERFORMANCE INFOR-**  
23 **MATION.**

24 (a) IN GENERAL.—

1           (1) DEVELOPMENT.—Not later than January 1,  
2           2011, the Secretary shall develop a Physician Com-  
3           pare Internet website with information on physicians  
4           enrolled in the Medicare program under section  
5           1866(j) of the Social Security Act (42 U.S.C.  
6           1395cc(j)) and other eligible professionals who par-  
7           ticipate in the Physician Quality Reporting Initiative  
8           under section 1848 of such Act (42 U.S.C. 1395w-  
9           4).

10           (2) PLAN.—Not later than January 1, 2013,  
11           and with respect to reporting periods that begin no  
12           earlier than January 1, 2012, the Secretary shall  
13           also implement a plan for making publicly available  
14           through Physician Compare, consistent with sub-  
15           section (c), information on physician performance  
16           that provides comparable information for the public  
17           on quality and patient experience measures with re-  
18           spect to physicians enrolled in the Medicare program  
19           under such section 1866(j). To the extent scientif-  
20           ically sound measures that are developed consistent  
21           with the requirements of this section are available,  
22           such information, to the extent practicable, shall in-  
23           clude—

24                           (A) measures collected under the Physician  
25           Quality Reporting Initiative;

1 (B) an assessment of patient health out-  
2 comes and the functional status of patients;

3 (C) an assessment of the continuity and  
4 coordination of care and care transitions, in-  
5 cluding episodes of care and risk-adjusted re-  
6 source use;

7 (D) an assessment of efficiency;

8 (E) an assessment of patient experience  
9 and patient, caregiver, and family engagement;

10 (F) an assessment of the safety, effective-  
11 ness, and timeliness of care; and

12 (G) other information as determined ap-  
13 propriate by the Secretary.

14 (b) OTHER REQUIRED CONSIDERATIONS.—In devel-  
15 oping and implementing the plan described in subsection  
16 (a)(2), the Secretary shall, to the extent practicable, in-  
17 clude—

18 (1) processes to assure that data made public,  
19 either by the Centers for Medicare & Medicaid Serv-  
20 ices or by other entities, is statistically valid and re-  
21 liable, including risk adjustment mechanisms used  
22 by the Secretary;

23 (2) processes by which a physician or other eli-  
24 gible professional whose performance on measures is  
25 being publicly reported has a reasonable opportunity,

1 as determined by the Secretary, to review his or her  
2 individual results before they are made public;

3 (3) processes by the Secretary to assure that  
4 the implementation of the plan and the data made  
5 available on Physician Compare provide a robust  
6 and accurate portrayal of a physician's performance;

7 (4) data that reflects the care provided to all  
8 patients seen by physicians, under both the Medicare  
9 program and, to the extent practicable, other payers,  
10 to the extent such information would provide a more  
11 accurate portrayal of physician performance;

12 (5) processes to ensure appropriate attribution  
13 of care when multiple physicians and other providers  
14 are involved in the care of a patient;

15 (6) processes to ensure timely statistical per-  
16 formance feedback is provided to physicians con-  
17 cerning the data reported under any program sub-  
18 ject to public reporting under this section; and

19 (7) implementation of computer and data sys-  
20 tems of the Centers for Medicare & Medicaid Serv-  
21 ices that support valid, reliable, and accurate public  
22 reporting activities authorized under this section.

23 (c) ENSURING PATIENT PRIVACY.—The Secretary  
24 shall ensure that information on physician performance  
25 and patient experience is not disclosed under this section

1 in a manner that violates sections 552 or 552a of title  
2 5, United States Code, with regard to the privacy of indi-  
3 vidually identifiable health information.

4 (d) FEEDBACK FROM MULTI-STAKEHOLDER  
5 GROUPS.—The Secretary shall take into consideration  
6 input provided by multi-stakeholder groups, consistent  
7 with sections 1890(b)(7) and 1890A of the Social Security  
8 Act, as added by section 3014 of this Act, in selecting  
9 quality measures for use under this section.

10 (e) CONSIDERATION OF TRANSITION TO VALUE-  
11 BASED PURCHASING.—In developing the plan under this  
12 subsection (a)(2), the Secretary shall, as the Secretary de-  
13 termines appropriate, consider the plan to transition to a  
14 value-based purchasing program for physicians and other  
15 practitioners developed under section 131 of the Medicare  
16 Improvements for Patients and Providers Act of 2008  
17 (Public Law 110–275).

18 (f) REPORT TO CONGRESS.—Not later than January  
19 1, 2015, the Secretary shall submit to Congress a report  
20 on the Physician Compare Internet website developed  
21 under subsection (a)(1). Such report shall include infor-  
22 mation on the efforts of and plans made by the Secretary  
23 to collect and publish data on physician quality and effi-  
24 ciency and on patient experience of care in support of  
25 value-based purchasing and consumer choice, together

1 with recommendations for such legislation and administra-  
2 tive action as the Secretary determines appropriate.

3 (g) EXPANSION.—At any time before the date on  
4 which the report is submitted under subsection (f), the  
5 Secretary may expand (including expansion to other pro-  
6 viders of services and suppliers under title XVIII of the  
7 Social Security Act) the information made available on  
8 such website.

9 (h) FINANCIAL INCENTIVES TO ENCOURAGE CON-  
10 SUMERS TO CHOOSE HIGH QUALITY PROVIDERS.—The  
11 Secretary may establish a demonstration program, not  
12 later than January 1, 2019, to provide financial incentives  
13 to Medicare beneficiaries who are furnished services by  
14 high quality physicians, as determined by the Secretary  
15 based on factors in subparagraphs (A) through (G) of sub-  
16 section (a)(2). In no case may Medicare beneficiaries be  
17 required to pay increased premiums or cost sharing or be  
18 subject to a reduction in benefits under title XVIII of the  
19 Social Security Act as a result of such demonstration pro-  
20 gram. The Secretary shall ensure that any such dem-  
21 onstration program does not disadvantage those bene-  
22 ficiaries without reasonable access to high performing phy-  
23 sicians or create financial inequities under such title.

24 (i) DEFINITIONS.—In this section:

1           (1) ELIGIBLE PROFESSIONAL.—The term “eli-  
2           gible professional” has the meaning given that term  
3           for purposes of the Physician Quality Reporting Ini-  
4           tiative under section 1848 of the Social Security Act  
5           (42 U.S.C. 1395w–4)

6           (2) PHYSICIAN.—The term “physician” has the  
7           meaning given that term in section 1861(r) of such  
8           Act (42 U.S.C. 1395x(r)).

9           (3) PHYSICIAN COMPARE.—The term “Physi-  
10          cian Compare” means the Internet website developed  
11          under subsection (a)(1).

12          (4) SECRETARY.—The term “Secretary” means  
13          the Secretary of Health and Human Services.

14 **SEC. 10332. AVAILABILITY OF MEDICARE DATA FOR PER-**  
15 **FORMANCE MEASUREMENT.**

16          (a) IN GENERAL.—Section 1874 of the Social Secu-  
17          rity Act (42 U.S.C. 1395kk) is amended by adding at the  
18          end the following new subsection:

19          “(e) AVAILABILITY OF MEDICARE DATA.—

20                 “(1) IN GENERAL.—Subject to paragraph (4),  
21                 the Secretary shall make available to qualified enti-  
22                 ties (as defined in paragraph (2)) data described in  
23                 paragraph (3) for the evaluation of the performance  
24                 of providers of services and suppliers.

1           “(2) QUALIFIED ENTITIES.—For purposes of  
2 this subsection, the term ‘qualified entity’ means a  
3 public or private entity that—

4           “(A) is qualified (as determined by the  
5 Secretary) to use claims data to evaluate the  
6 performance of providers of services and sup-  
7 pliers on measures of quality, efficiency, effec-  
8 tiveness, and resource use; and

9           “(B) agrees to meet the requirements de-  
10 scribed in paragraph (4) and meets such other  
11 requirements as the Secretary may specify, such  
12 as ensuring security of data.

13           “(3) DATA DESCRIBED.—The data described in  
14 this paragraph are standardized extracts (as deter-  
15 mined by the Secretary) of claims data under parts  
16 A, B, and D for items and services furnished under  
17 such parts for one or more specified geographic  
18 areas and time periods requested by a qualified enti-  
19 ty. The Secretary shall take such actions as the Sec-  
20 retary deems necessary to protect the identity of in-  
21 dividuals entitled to or enrolled for benefits under  
22 such parts.

23           “(4) REQUIREMENTS.—

24           “(A) FEE.—Data described in paragraph  
25 (3) shall be made available to a qualified entity

1 under this subsection at a fee equal to the cost  
2 of making such data available. Any fee collected  
3 pursuant to the preceding sentence shall be de-  
4 posited into the Federal Supplementary Medical  
5 Insurance Trust Fund under section 1841.

6 “(B) SPECIFICATION OF USES AND METH-  
7 ODOLOGIES.—A qualified entity requesting data  
8 under this subsection shall—

9 “(i) submit to the Secretary a descrip-  
10 tion of the methodologies that such quali-  
11 fied entity will use to evaluate the perform-  
12 ance of providers of services and suppliers  
13 using such data;

14 “(ii)(I) except as provided in sub-  
15 clause (II), if available, use standard meas-  
16 ures, such as measures endorsed by the en-  
17 tity with a contract under section 1890(a)  
18 and measures developed pursuant to sec-  
19 tion 931 of the Public Health Service Act;  
20 or

21 “(II) use alternative measures if the  
22 Secretary, in consultation with appropriate  
23 stakeholders, determines that use of such  
24 alternative measures would be more valid,  
25 reliable, responsive to consumer pref-

1 erences, cost-effective, or relevant to di-  
2 mensions of quality and resource use not  
3 addressed by such standard measures;

4 “(iii) include data made available  
5 under this subsection with claims data  
6 from sources other than claims data under  
7 this title in the evaluation of performance  
8 of providers of services and suppliers;

9 “(iv) only include information on the  
10 evaluation of performance of providers and  
11 suppliers in reports described in subpara-  
12 graph (C);

13 “(v) make available to providers of  
14 services and suppliers, upon their request,  
15 data made available under this subsection;  
16 and

17 “(vi) prior to their release, submit to  
18 the Secretary the format of reports under  
19 subparagraph (C).

20 “(C) REPORTS.—Any report by a qualified  
21 entity evaluating the performance of providers  
22 of services and suppliers using data made avail-  
23 able under this subsection shall—

24 “(i) include an understandable de-  
25 scription of the measures, which shall in-

1           clude quality measures and the rationale  
2           for use of other measures described in sub-  
3           paragraph (B)(ii)(II), risk adjustment  
4           methods, physician attribution methods,  
5           other applicable methods, data specifica-  
6           tions and limitations, and the sponsors, so  
7           that consumers, providers of services and  
8           suppliers, health plans, researchers, and  
9           other stakeholders can assess such reports;

10           “(ii) be made available confidentially,  
11           to any provider of services or supplier to be  
12           identified in such report, prior to the pub-  
13           lic release of such report, and provide an  
14           opportunity to appeal and correct errors;

15           “(iii) only include information on a  
16           provider of services or supplier in an ag-  
17           gregate form as determined appropriate by  
18           the Secretary; and

19           “(iv) except as described in clause (ii),  
20           be made available to the public.

21           “(D) APPROVAL AND LIMITATION OF  
22           USES.—The Secretary shall not make data de-  
23           scribed in paragraph (3) available to a qualified  
24           entity unless the qualified entity agrees to re-  
25           lease the information on the evaluation of per-

1 formance of providers of services and suppliers.  
2 Such entity shall only use such data, and infor-  
3 mation derived from such evaluation, for the re-  
4 ports under subparagraph (C). Data released to  
5 a qualified entity under this subsection shall  
6 not be subject to discovery or admission as evi-  
7 dence in judicial or administrative proceedings  
8 without consent of the applicable provider of  
9 services or supplier.”.

10 (b) EFFECTIVE DATE.—The amendment made by  
11 subsection (a) shall take effect on January 1, 2012.

12 **SEC. 10333. COMMUNITY-BASED COLLABORATIVE CARE**  
13 **NETWORKS.**

14 Part D of title III of the Public Health Service Act  
15 (42 U.S.C. 254b et seq.) is amended by adding at the end  
16 the following new subpart:

17 **“Subpart XI—Community-Based Collaborative Care**  
18 **Network Program**

19 **“SEC. 340H. COMMUNITY-BASED COLLABORATIVE CARE**  
20 **NETWORK PROGRAM.**

21 “(a) IN GENERAL.—The Secretary may award grants  
22 to eligible entities to support community-based collabo-  
23 rative care networks that meet the requirements of sub-  
24 section (b).

1       “(b) COMMUNITY-BASED COLLABORATIVE CARE  
2 NETWORKS.—

3           “(1) DESCRIPTION.—A community-based col-  
4 laborative care network (referred to in this section  
5 as a ‘network’) shall be a consortium of health care  
6 providers with a joint governance structure (includ-  
7 ing providers within a single entity) that provides  
8 comprehensive coordinated and integrated health  
9 care services (as defined by the Secretary) for low-  
10 income populations.

11          “(2) REQUIRED INCLUSION.—A network shall  
12 include the following providers (unless such provider  
13 does not exist within the community, declines or re-  
14 fuses to participate, or places unreasonable condi-  
15 tions on their participation):

16           “(A) A hospital that meets the criteria in  
17 section 1923(b)(1) of the Social Security Act;  
18 and

19           “(B) All Federally qualified health centers  
20 (as defined in section 1861(aa) of the Social  
21 Security Act located in the community.

22          “(3) PRIORITY.—In awarding grants, the Sec-  
23 retary shall give priority to networks that include—

24           “(A) the capability to provide the broadest  
25 range of services to low-income individuals;

1           “(B) the broadest range of providers that  
2           currently serve a high volume of low-income in-  
3           dividuals; and

4           “(C) a county or municipal department of  
5           health.

6           “(c) APPLICATION.—

7           “(1) APPLICATION.—A network described in  
8           subsection (b) shall submit an application to the  
9           Secretary.

10          “(2) RENEWAL.—In subsequent years, based on  
11          the performance of grantees, the Secretary may pro-  
12          vide renewal grants to prior year grant recipients.

13          “(d) USE OF FUNDS.—

14          “(1) USE BY GRANTEES.—Grant funds may be  
15          used for the following activities:

16                 “(A) Assist low-income individuals to—

17                         “(i) access and appropriately use  
18                         health services;

19                         “(ii) enroll in health coverage pro-  
20                         grams; and

21                         “(iii) obtain a regular primary care  
22                         provider or a medical home.

23                 “(B) Provide case management and care  
24                 management.

1           “(C) Perform health outreach using neigh-  
2           borhood health workers or through other  
3           means.

4           “(D) Provide transportation.

5           “(E) Expand capacity, including through  
6           telehealth, after-hours services or urgent care.

7           “(F) Provide direct patient care services.

8           “(2) GRANT FUNDS TO HRSA GRANTEES.—The  
9           Secretary may limit the percent of grant funding  
10          that may be spent on direct care services provided  
11          by grantees of programs administered by the Health  
12          Resources and Services Administration or impose  
13          other requirements on such grantees deemed nec-  
14          essary.

15          “(e) AUTHORIZATION OF APPROPRIATIONS.—There  
16          are authorized to be appropriated to carry out this section  
17          such sums as may be necessary for each of fiscal years  
18          2011 through 2015.”.

19   **SEC. 10334. MINORITY HEALTH.**

20          (a) OFFICE OF MINORITY HEALTH.—

21                  (1) IN GENERAL.—Section 1707 of the Public  
22          Health Service Act (42 U.S.C. 300u-6) is amend-  
23          ed—

24                          (A) in subsection (a), by striking “within  
25          the Office of Public Health and Science” and

1 all that follows through the end and inserting “.

2 The Office of Minority Health as existing on

3 the date of enactment of the Patient Protection

4 and Affordable Care Act shall be transferred to

5 the Office of the Secretary in such manner that

6 there is established in the Office of the Sec-

7 retary, the Office of Minority Health, which

8 shall be headed by the Deputy Assistant Sec-

9 retary for Minority Health who shall report di-

10 rectly to the Secretary, and shall retain and

11 strengthen authorities (as in existence on such

12 date of enactment) for the purpose of improving

13 minority health and the quality of health care

14 minorities receive, and eliminating racial and

15 ethnic disparities. In carrying out this sub-

16 section, the Secretary, acting through the Dep-

17 uty Assistant Secretary, shall award grants,

18 contracts, enter into memoranda of under-

19 standing, cooperative, interagency, intra-agency

20 and other agreements with public and nonprofit

21 private entities, agencies, as well as Depart-

22 mental and Cabinet agencies and organizations,

23 and with organizations that are indigenous

24 human resource providers in communities of

25 color to assure improved health status of racial

1           and ethnic minorities, and shall develop meas-  
2           ures to evaluate the effectiveness of activities  
3           aimed at reducing health disparities and sup-  
4           porting the local community. Such measures  
5           shall evaluate community outreach activities,  
6           language services, workforce cultural com-  
7           petence, and other areas as determined by the  
8           Secretary.”; and

9                       (B) by striking subsection (h) and insert-  
10           ing the following:

11           “(h) AUTHORIZATION OF APPROPRIATIONS.—For the  
12           purpose of carrying out this section, there are authorized  
13           to be appropriated such sums as may be necessary for  
14           each of fiscal years 2011 through 2016.”.

15                       (2) TRANSFER OF FUNCTIONS.—There are  
16           transferred to the Office of Minority Health in the  
17           office of the Secretary of Health and Human Serv-  
18           ices, all duties, responsibilities, authorities, account-  
19           abilities, functions, staff, funds, award mechanisms,  
20           and other entities under the authority of the Office  
21           of Minority Health of the Public Health Service as  
22           in effect on the date before the date of enactment  
23           of this Act, which shall continue in effect according  
24           to the terms in effect on the date before such date  
25           of enactment, until modified, terminated, super-

1       seded, set aside, or revoked in accordance with law  
2       by the President, the Secretary, a court of com-  
3       petent jurisdiction, or by operation of law.

4           (3) REPORTS.—Not later than 1 year after the  
5       date of enactment of this section, and biennially  
6       thereafter, the Secretary of Health and Human  
7       Services shall prepare and submit to the appropriate  
8       committees of Congress a report describing the ac-  
9       tivities carried out under section 1707 of the Public  
10      Health Service Act (as amended by this subsection)  
11      during the period for which the report is being pre-  
12      pared. Not later than 1 year after the date of enact-  
13      ment of this section, and biennially thereafter, the  
14      heads of each of the agencies of the Department of  
15      Health and Human Services shall submit to the  
16      Deputy Assistant Secretary for Minority Health a  
17      report summarizing the minority health activities of  
18      each of the respective agencies.

19      (b) ESTABLISHMENT OF INDIVIDUAL OFFICES OF  
20      MINORITY HEALTH WITHIN THE DEPARTMENT OF  
21      HEALTH AND HUMAN SERVICES.—

22           (1) IN GENERAL.—Title XVII of the Public  
23      Health Service Act (42 U.S.C. 300u et seq.) is  
24      amended by inserting after section 1707 the fol-  
25      lowing section:

1 **“SEC. 1707A. INDIVIDUAL OFFICES OF MINORITY HEALTH**  
2 **WITHIN THE DEPARTMENT.**

3 “(a) IN GENERAL.—The head of each agency speci-  
4 fied in subsection (b)(1) shall establish within the agency  
5 an office to be known as the Office of Minority Health.  
6 The head of each such Office shall be appointed by the  
7 head of the agency within which the Office is established,  
8 and shall report directly to the head of the agency. The  
9 head of such agency shall carry out this section (as this  
10 section relates to the agency) acting through such Direc-  
11 tor.

12 “(b) SPECIFIED AGENCIES.—The agencies referred  
13 to in subsection (a) are the Centers for Disease Control  
14 and Prevention, the Health Resources and Services Ad-  
15 ministration, the Substance Abuse and Mental Health  
16 Services Administration, the Agency for Healthcare Re-  
17 search and Quality, the Food and Drug Administration,  
18 and the Centers for Medicare & Medicaid Services.

19 “(c) DIRECTOR; APPOINTMENT.—Each Office of Mi-  
20 nority Health established in an agency listed in subsection  
21 (a) shall be headed by a director, with documented experi-  
22 ence and expertise in minority health services research and  
23 health disparities elimination.

24 “(d) REFERENCES.—Except as otherwise specified,  
25 any reference in Federal law to an Office of Minority  
26 Health (in the Department of Health and Human Serv-

1 ices) is deemed to be a reference to the Office of Minority  
2 Health in the Office of the Secretary.

3 “(e) FUNDING.—

4 “(1) ALLOCATIONS.—Of the amounts appro-  
5 priated for a specified agency for a fiscal year, the  
6 Secretary must designate an appropriate amount of  
7 funds for the purpose of carrying out activities  
8 under this section through the minority health office  
9 of the agency. In reserving an amount under the  
10 preceding sentence for a minority health office for a  
11 fiscal year, the Secretary shall reduce, by substan-  
12 tially the same percentage, the amount that other-  
13 wise would be available for each of the programs of  
14 the designated agency involved.

15 “(2) AVAILABILITY OF FUNDS FOR STAFF-  
16 ING.—The purposes for which amounts made avail-  
17 able under paragraph may be expended by a minor-  
18 ity health office include the costs of employing staff  
19 for such office.”.

20 (2) NO NEW REGULATORY AUTHORITY.—Noth-  
21 ing in this subsection and the amendments made by  
22 this subsection may be construed as establishing reg-  
23 ulatory authority or modifying any existing regu-  
24 latory authority.

1           (3) LIMITATION ON TERMINATION.—Notwith-  
2 standing any other provision of law, a Federal office  
3 of minority health or Federal appointive position  
4 with primary responsibility over minority health  
5 issues that is in existence in an office of agency of  
6 the Department of Health and Human Services on  
7 the date of enactment of this section shall not be  
8 terminated, reorganized, or have any of its power or  
9 duties transferred unless such termination, reorga-  
10 nization, or transfer is approved by an Act of Con-  
11 gress.

12           (c) REDESIGNATION OF NATIONAL CENTER ON MI-  
13 NORITY HEALTH AND HEALTH DISPARITIES.—

14           (1) REDESIGNATION.—Title IV of the Public  
15 Health Service Act (42 U.S.C. 281 et seq.) is  
16 amended—

17                   (A) by redesignating subpart 6 of part E  
18 as subpart 20;

19                   (B) by transferring subpart 20, as so re-  
20 designated, to part C of such title IV;

21                   (C) by inserting subpart 20, as so redesign-  
22 ated, after subpart 19 of such part C; and

23                   (D) in subpart 20, as so redesignated—

1 (i) by redesignating sections 485E  
2 through 485H as sections 464z-3 through  
3 464z-6, respectively;

4 (ii) by striking “National Center on  
5 Minority Health and Health Disparities”  
6 each place such term appears and inserting  
7 “National Institute on Minority Health  
8 and Health Disparities”; and

9 (iii) by striking “Center” each place  
10 such term appears and inserting “Insti-  
11 tute”.

12 (2) PURPOSE OF INSTITUTE; DUTIES.—Section  
13 464z-3 of the Public Health Service Act, as so re-  
14 designated, is amended—

15 (A) in subsection (h)(1), by striking “re-  
16 search endowments at centers of excellence  
17 under section 736.” and inserting the following:

18 “research endowments—  
19 “(1) at centers of excellence under section 736;

20 and

21 “(2) at centers of excellence under section  
22 464z-4.”;

23 (B) in subsection (h)(2)(A), by striking  
24 “average” and inserting “median”; and

25 (C) by adding at the end the following:

1           “(h) INTERAGENCY COORDINATION.—The Director  
2 of the Institute, as the primary Federal officials with re-  
3 sponsibility for coordinating all research and activities  
4 conducted or supported by the National Institutes of  
5 Health on minority health and health disparities, shall  
6 plan, coordinate, review and evaluate research and other  
7 activities conducted or supported by the Institutes and  
8 Centers of the National Institutes of Health.”.

9           (3) TECHNICAL AND CONFORMING AMEND-  
10       MENTS.—

11           (A) Section 401(b)(24) of the Public  
12       Health Service Act (42 U.S.C. 281(b)(24)) is  
13       amended by striking “Center” and inserting  
14       “Institute”.

15           (B) Subsection (d)(1) of section 903 of the  
16       Public Health Service Act (42 U.S.C. 299a-  
17       1(d)(1)) is amended by striking “section 485E”  
18       and inserting “section 464z-3”.

19       **SEC. 10335. TECHNICAL CORRECTION TO THE HOSPITAL**  
20                               **VALUE-BASED PURCHASING PROGRAM.**

21       Section 1886(o)(2)A) of the Social Security Act, as  
22       added by section 3001, is amended, in the first sentence,  
23       by inserting “, other than measures of readmissions,”  
24       after “shall select measures”.

1 **SEC. 10336. GAO STUDY AND REPORT ON MEDICARE BENE-**  
2 **FICIARY ACCESS TO HIGH-QUALITY DIALYSIS**  
3 **SERVICES.**

4 (a) STUDY.—

5 (1) IN GENERAL.—The Comptroller General of  
6 the United States shall conduct a study on the im-  
7 pact on Medicare beneficiary access to high-quality  
8 dialysis services of including specified oral drugs  
9 that are furnished to such beneficiaries for the treat-  
10 ment of end stage renal disease in the bundled pro-  
11 spective payment system under section 1881(b)(14)  
12 of the Social Security Act (42 U.S.C. 1395rr(b)(14))  
13 (pursuant to the proposed rule published by the Sec-  
14 retary of Health and Human Services in the Federal  
15 Register on September 29, 2009 (74 Fed. Reg.  
16 49922 et seq.)). Such study shall include an analysis  
17 of—

18 (A) the ability of providers of services and  
19 renal dialysis facilities to furnish specified oral  
20 drugs or arrange for the provision of such  
21 drugs;

22 (B) the ability of providers of services and  
23 renal dialysis facilities to comply, if necessary,  
24 with applicable State laws (such as State phar-  
25 macy licensure requirements) in order to fur-  
26 nish specified oral drugs;

1 (C) whether appropriate quality measures  
2 exist to safeguard care for Medicare bene-  
3 ficiaries being furnished specified oral drugs by  
4 providers of services and renal dialysis facilities;  
5 and

6 (D) other areas determined appropriate by  
7 the Comptroller General.

8 (2) SPECIFIED ORAL DRUG DEFINED.—For  
9 purposes of paragraph (1), the term “specified oral  
10 drug” means a drug or biological for which there is  
11 no injectable equivalent (or other non-oral form of  
12 administration).

13 (b) REPORT.—Not later than 1 year after the date  
14 of the enactment of this Act, the Comptroller General of  
15 the United States shall submit to Congress a report con-  
16 taining the results of the study conducted under sub-  
17 section (a), together with recommendations for such legis-  
18 lation and administrative action as the Comptroller Gen-  
19 eral determines appropriate.

## 20 **Subtitle D—Provisions Relating to** 21 **Title IV**

### 22 **SEC. 10401. AMENDMENTS TO SUBTITLE A.**

23 (a) Section 4001(h)(4) and (5) of this Act is amended  
24 by striking “2010” each place such appears and inserting  
25 “2020”.

1 (b) Section 4002(c) of this Act is amended—

2 (1) by striking “research and health  
3 screenings” and inserting “research, health  
4 screenings, and initiatives”; and

5 (2) by striking “for Preventive” and inserting  
6 “Regarding Preventive”.

7 (c) Section 4004(a)(4) of this Act is amended by  
8 striking “a Gateway” and inserting “an Exchange”.

9 **SEC. 10402. AMENDMENTS TO SUBTITLE B.**

10 (a) Section 399Z-1(a)(1(A) of the Public Health  
11 Service Act, as added by section 4101(b) of this Act, is  
12 amended by inserting “and vision” after “oral”.

13 (b) Section 1861(hhh)(4)(G) of the Social Security  
14 Act, as added by section 4103(b), is amended to read as  
15 follows:

16 “(G) A beneficiary shall be eligible to re-  
17 ceive only an initial preventive physical exam-  
18 ination (as defined under subsection (ww)(1))  
19 during the 12-month period after the date that  
20 the beneficiary’s coverage begins under part B  
21 and shall be eligible to receive personalized pre-  
22 vention plan services under this subsection each  
23 year thereafter provided that the beneficiary  
24 has not received either an initial preventive  
25 physical examination or personalized prevention

1           plan services within the preceding 12-month pe-  
2           riod.”.

3 **SEC. 10403. AMENDMENTS TO SUBTITLE C.**

4           Section 4201 of this Act is amended—

5           (1) in subsection (a), by adding before the pe-  
6           riod the following: “, with not less than 20 percent  
7           of such grants being awarded to rural and frontier  
8           areas”;

9           (2) in subsection (c)(2)(B)(vii), by striking  
10          “both urban and rural areas” and inserting “urban,  
11          rural, and frontier areas”; and

12          (3) in subsection (f), by striking “each fiscal  
13          years” and inserting “each of fiscal year”.

14 **SEC. 10404. AMENDMENTS TO SUBTITLE D.**

15          Section 399MM(2) of the Public Health Service Act,  
16          as added by section 4303 of this Act, is amended by strik-  
17          ing “by ensuring” and inserting “and ensuring”.

18 **SEC. 10405. AMENDMENTS TO SUBTITLE E.**

19          Subtitle E of title IV of this Act is amended by strik-  
20          ing section 4401.

21 **SEC. 10406. AMENDMENT RELATING TO WAIVING COINSUR-**  
22 **ANCE FOR PREVENTIVE SERVICES.**

23          Section 4104(b) of this Act is amended to read as  
24          follows:

1           “(b) PAYMENT AND ELIMINATION OF COINSURANCE  
2 IN ALL SETTINGS.—Section 1833(a)(1) of the Social Se-  
3 curity Act (42 U.S.C. 1395l(a)(1)), as amended by section  
4 4103(c)(1), is amended—

5           “(1) in subparagraph (T), by inserting ‘(or 100  
6 percent if such services are recommended with a  
7 grade of A or B by the United States Preventive  
8 Services Task Force for any indication or population  
9 and are appropriate for the individual)’ after ‘80  
10 percent’;

11           “(2) in subparagraph (W)—

12           “(A) in clause (i), by inserting ‘(if such  
13 subparagraph were applied, by substituting  
14 “100 percent” for “80 percent”)’ after ‘sub-  
15 paragraph (D)’; and

16           “(B) in clause (ii), by striking ‘80 percent’  
17 and inserting ‘100 percent’;

18           “(3) by striking ‘and’ before ‘(X)’; and

19           “(4) by inserting before the semicolon at the  
20 end the following: ‘, and (Y) with respect to preven-  
21 tive services described in subparagraphs (A) and (B)  
22 of section 1861(ddd)(3) that are appropriate for the  
23 individual and, in the case of such services described  
24 in subparagraph (A), are recommended with a grade  
25 of A or B by the United States Preventive Services

1 Task Force for any indication or population, the  
2 amount paid shall be 100 percent of (i) except as  
3 provided in clause (ii), the lesser of the actual  
4 charge for the services or the amount determined  
5 under the fee schedule that applies to such services  
6 under this part, and (ii) in the case of such services  
7 that are covered OPD services (as defined in sub-  
8 section (t)(1)(B)), the amount determined under  
9 subsection (t)’.’.

10 **SEC. 10407. BETTER DIABETES CARE.**

11 (a) **SHORT TITLE.**—This section may be cited as the  
12 “Catalyst to Better Diabetes Care Act of 2009”.

13 (b) **NATIONAL DIABETES REPORT CARD.**—

14 (1) **IN GENERAL.**—The Secretary, in collabora-  
15 tion with the Director of the Centers for Disease  
16 Control and Prevention (referred to in this section  
17 as the “Director”), shall prepare on a biennial basis  
18 a national diabetes report card (referred to in this  
19 section as a “Report Card”) and, to the extent pos-  
20 sible, for each State.

21 (2) **CONTENTS.**—

22 (A) **IN GENERAL.**—Each Report Card shall  
23 include aggregate health outcomes related to in-  
24 dividuals diagnosed with diabetes and  
25 prediabetes including—

1 (i) preventative care practices and  
2 quality of care;

3 (ii) risk factors; and

4 (iii) outcomes.

5 (B) UPDATED REPORTS.—Each Report  
6 Card that is prepared after the initial Report  
7 Card shall include trend analysis for the Nation  
8 and, to the extent possible, for each State, for  
9 the purpose of—

10 (i) tracking progress in meeting estab-  
11 lished national goals and objectives for im-  
12 proving diabetes care, costs, and preva-  
13 lence (including Healthy People 2010); and

14 (ii) informing policy and program de-  
15 velopment.

16 (3) AVAILABILITY.—The Secretary, in collabo-  
17 ration with the Director, shall make each Report  
18 Card publicly available, including by posting the Re-  
19 port Card on the Internet.

20 (c) IMPROVEMENT OF VITAL STATISTICS COLLEC-  
21 TION.—

22 (1) IN GENERAL.—The Secretary, acting  
23 through the Director of the Centers for Disease  
24 Control and Prevention and in collaboration with ap-  
25 propriate agencies and States, shall—

1 (A) promote the education and training of  
2 physicians on the importance of birth and death  
3 certificate data and how to properly complete  
4 these documents, including the collection of  
5 such data for diabetes and other chronic dis-  
6 eases;

7 (B) encourage State adoption of the latest  
8 standard revisions of birth and death certifi-  
9 cates; and

10 (C) work with States to re-engineer their  
11 vital statistics systems in order to provide cost-  
12 effective, timely, and accurate vital systems  
13 data.

14 (2) DEATH CERTIFICATE ADDITIONAL LAN-  
15 GUAGE.—In carrying out this subsection, the Sec-  
16 retary may promote improvements to the collection  
17 of diabetes mortality data, including the addition of  
18 a question for the individual certifying the cause of  
19 death regarding whether the deceased had diabetes.

20 (d) STUDY ON APPROPRIATE LEVEL OF DIABETES  
21 MEDICAL EDUCATION.—

22 (1) IN GENERAL.—The Secretary shall, in col-  
23 laboration with the Institute of Medicine and appro-  
24 priate associations and councils, conduct a study of  
25 the impact of diabetes on the practice of medicine in

1 the United States and the appropriateness of the  
2 level of diabetes medical education that should be re-  
3 quired prior to licensure, board certification, and  
4 board recertification.

5 (2) REPORT.—Not later than 2 years after the  
6 date of the enactment of this Act, the Secretary  
7 shall submit a report on the study under paragraph  
8 (1) to the Committees on Ways and Means and En-  
9 ergy and Commerce of the House of Representatives  
10 and the Committees on Finance and Health, Edu-  
11 cation, Labor, and Pensions of the Senate.

12 (e) AUTHORIZATION OF APPROPRIATIONS.—There  
13 are authorized to be appropriated to carry out this section  
14 such sums as may be necessary.

15 **SEC. 10408. GRANTS FOR SMALL BUSINESSES TO PROVIDE**  
16 **COMPREHENSIVE WORKPLACE WELLNESS**  
17 **PROGRAMS.**

18 (a) ESTABLISHMENT.—The Secretary shall award  
19 grants to eligible employers to provide their employees  
20 with access to comprehensive workplace wellness programs  
21 (as described under subsection (c)).

22 (b) SCOPE.—

23 (1) DURATION.—The grant program estab-  
24 lished under this section shall be conducted for a 5-  
25 year period.

1           (2) ELIGIBLE EMPLOYER.—The term “eligible  
2 employer” means an employer (including a non-prof-  
3 it employer) that—

4           (A) employs less than 100 employees who  
5 work 25 hours or greater per week; and

6           (B) does not provide a workplace wellness  
7 program as of the date of enactment of this  
8 Act.

9           (c) COMPREHENSIVE WORKPLACE WELLNESS PRO-  
10 GRAMS.—

11           (1) CRITERIA.—The Secretary shall develop  
12 program criteria for comprehensive workplace  
13 wellness programs under this section that are based  
14 on and consistent with evidence-based research and  
15 best practices, including research and practices as  
16 provided in the Guide to Community Preventive  
17 Services, the Guide to Clinical Preventive Services,  
18 and the National Registry for Effective Programs.

19           (2) REQUIREMENTS.—A comprehensive work-  
20 place wellness program shall be made available by an  
21 eligible employer to all employees and include the  
22 following components:

23           (A) Health awareness initiatives (including  
24 health education, preventive screenings, and  
25 health risk assessments).

1           (B) Efforts to maximize employee engage-  
2           ment (including mechanisms to encourage em-  
3           ployee participation).

4           (C) Initiatives to change unhealthy behav-  
5           iors and lifestyle choices (including counseling,  
6           seminars, online programs, and self-help mate-  
7           rials).

8           (D) Supportive environment efforts (in-  
9           cluding workplace policies to encourage healthy  
10          lifestyles, healthy eating, increased physical ac-  
11          tivity, and improved mental health).

12          (d) APPLICATION.—An eligible employer desiring to  
13          participate in the grant program under this section shall  
14          submit an application to the Secretary, in such manner  
15          and containing such information as the Secretary may re-  
16          quire, which shall include a proposal for a comprehensive  
17          workplace wellness program that meet the criteria and re-  
18          quirements described under subsection (c).

19          (e) AUTHORIZATION OF APPROPRIATION.—For pur-  
20          poses of carrying out the grant program under this sec-  
21          tion, there is authorized to be appropriated \$200,000,000  
22          for the period of fiscal years 2011 through 2015. Amounts  
23          appropriated pursuant to this subsection shall remain  
24          available until expended.

1 **SEC. 10409. CURES ACCELERATION NETWORK.**

2 (a) SHORT TITLE.—This section may be cited as the  
3 “Cures Acceleration Network Act of 2009”.

4 (b) REQUIREMENT FOR THE DIRECTOR OF NIH TO  
5 ESTABLISH A CURES ACCELERATION NETWORK.—Sec-  
6 tion 402(b) of the Public Health Service Act (42 U.S.C.  
7 282(b)) is amended—

8 (1) in paragraph (22), by striking “and” at the  
9 end;

10 (2) in paragraph (23), by striking the period  
11 and inserting “; and”; and

12 (3) by inserting after paragraph (23), the fol-  
13 lowing:

14 “(24) implement the Cures Acceleration Net-  
15 work described in section 402C.”.

16 (c) ACCEPTING GIFTS TO SUPPORT THE CURES AC-  
17 CELERATION NETWORK.—Section 499(c)(1) of the Public  
18 Health Service Act (42 U.S.C. 290b(c)(1)) is amended by  
19 adding at the end the following:

20 “(E) The Cures Acceleration Network de-  
21 scribed in section 402C.”.

22 (d) ESTABLISHMENT OF THE CURES ACCELERATION  
23 NETWORK.—Part A of title IV of the Public Health Serv-  
24 ice Act is amended by inserting after section 402B (42  
25 U.S.C. 282b) the following:

1 **“SEC. 402C. CURES ACCELERATION NETWORK.**

2 “(a) DEFINITIONS.—In this section:

3 “(1) BIOLOGICAL PRODUCT.—The term ‘bio-  
4 logical product’ has the meaning given such term in  
5 section 351 of the Public Health Service Act.

6 “(2) DRUG; DEVICE.—The terms ‘drug’ and  
7 ‘device’ have the meanings given such terms in sec-  
8 tion 201 of the Federal Food, Drug, and Cosmetic  
9 Act.

10 “(3) HIGH NEED CURE.—The term ‘high need  
11 cure’ means a drug (as that term is defined by sec-  
12 tion 201(g)(1) of the Federal Food, Drug, and Cos-  
13 metic Act, biological product (as that term is defined  
14 by section 262(i)), or device (as that term is defined  
15 by section 201(h) of the Federal Food, Drug, and  
16 Cosmetic Act) that, in the determination of the Di-  
17 rector of NIH—

18 “(A) is a priority to diagnose, mitigate,  
19 prevent, or treat harm from any disease or con-  
20 dition; and

21 “(B) for which the incentives of the com-  
22 mercial market are unlikely to result in its ade-  
23 quate or timely development.

24 “(4) MEDICAL PRODUCT.—The term ‘medical  
25 product’ means a drug, device, biological product, or

1 product that is a combination of drugs, devices, and  
2 biological products.

3 “(b) ESTABLISHMENT OF THE CURES ACCELERA-  
4 TION NETWORK.—Subject to the appropriation of funds  
5 as described in subsection (g), there is established within  
6 the Office of the Director of NIH a program to be known  
7 as the Cures Acceleration Network (referred to in this sec-  
8 tion as ‘CAN’), which shall—

9 “(1) be under the direction of the Director of  
10 NIH, taking into account the recommendations of a  
11 CAN Review Board (referred to in this section as  
12 the ‘Board’), described in subsection (d); and

13 “(2) award grants and contracts to eligible enti-  
14 ties, as described in subsection (e), to accelerate the  
15 development of high need cures, including through  
16 the development of medical products and behavioral  
17 therapies.

18 “(c) FUNCTIONS.—The functions of the CAN are  
19 to—

20 “(1) conduct and support revolutionary ad-  
21 vances in basic research, translating scientific dis-  
22 coveries from bench to bedside;

23 “(2) award grants and contracts to eligible enti-  
24 ties to accelerate the development of high need  
25 cures;

1           “(3) provide the resources necessary for govern-  
2           ment agencies, independent investigators, research  
3           organizations, biotechnology companies, academic re-  
4           search institutions, and other entities to develop  
5           high need cures;

6           “(4) reduce the barriers between laboratory dis-  
7           coveries and clinical trials for new therapies; and

8           “(5) facilitate review in the Food and Drug Ad-  
9           ministration for the high need cures funded by the  
10          CAN, through activities that may include—

11                 “(A) the facilitation of regular and ongoing  
12                 communication with the Food and Drug Ad-  
13                 ministration regarding the status of activities  
14                 conducted under this section;

15                 “(B) ensuring that such activities are co-  
16                 ordinated with the approval requirements of the  
17                 Food and Drug Administration, with the goal  
18                 of expediting the development and approval of  
19                 countermeasures and products; and

20                 “(C) connecting interested persons with  
21                 additional technical assistance made available  
22                 under section 565 of the Federal Food, Drug,  
23                 and Cosmetic Act.

24          “(d) CAN BOARD.—

1           “(1) ESTABLISHMENT.—There is established a  
2           Cures Acceleration Network Review Board (referred  
3           to in this section as the ‘Board’), which shall advise  
4           the Director of NIH on the conduct of the activities  
5           of the Cures Acceleration Network.

6           “(2) MEMBERSHIP.—

7           “(A) IN GENERAL.—

8           “(i) APPOINTMENT.—The Board shall  
9           be comprised of 24 members who are ap-  
10          pointed by the Secretary and who serve at  
11          the pleasure of the Secretary.

12          “(ii) CHAIRPERSON AND VICE CHAIR-  
13          PERSON.—The Secretary shall designate,  
14          from among the 24 members appointed  
15          under clause (i), one Chairperson of the  
16          Board (referred to in this section as the  
17          ‘Chairperson’) and one Vice Chairperson.

18          “(B) TERMS.—

19          “(i) IN GENERAL.—Each member  
20          shall be appointed to serve a 4-year term,  
21          except that any member appointed to fill a  
22          vacancy occurring prior to the expiration  
23          of the term for which the member’s prede-  
24          cessor was appointed shall be appointed for  
25          the remainder of such term.



266

1                   “(ee) bioinformatics and  
2                   gene therapy;

3                   “(ff) medical instrumenta-  
4                   tion; and

5                   “(gg) regulatory review and  
6                   approval of medical products,

7                   the Secretary shall select at least 1 in-  
8                   dividual who is eminent in such fields.

9                   “(II) At least 4 individuals shall  
10                  be recognized leaders in professional  
11                  venture capital or private equity orga-  
12                  nizations and have demonstrated ex-  
13                  perience in private equity investing.

14                  “(III) At least 8 individuals shall  
15                  represent disease advocacy organiza-  
16                  tions.

17                  “(3) EX-OFFICIO MEMBERS.—

18                  “(A) APPOINTMENT.—In addition to the  
19                  24 Board members described in paragraph (2),  
20                  the Secretary shall appoint as ex-officio mem-  
21                  bers of the Board—

22                  “(i) a representative of the National  
23                  Institutes of Health, recommended by the  
24                  Secretary of the Department of Health and  
25                  Human Services;

1                   “(ii) a representative of the Office of  
2                   the Assistant Secretary of Defense for  
3                   Health Affairs, recommended by the Sec-  
4                   retary of Defense;

5                   “(iii) a representative of the Office of  
6                   the Under Secretary for Health for the  
7                   Veterans Health Administration, rec-  
8                   ommended by the Secretary of Veterans  
9                   Affairs;

10                   “(iv) a representative of the National  
11                   Science Foundation, recommended by the  
12                   Chair of the National Science Board; and

13                   “(v) a representative of the Food and  
14                   Drug Administration, recommended by the  
15                   Commissioner of Food and Drugs.

16                   “(B) TERMS.—Each ex-officio member  
17                   shall serve a 3-year term on the Board, except  
18                   that the Chairperson may adjust the terms of  
19                   the initial ex-officio members in order to pro-  
20                   vide for a staggered term of appointment for all  
21                   such members.

22                   “(4) RESPONSIBILITIES OF THE BOARD AND  
23                   THE DIRECTOR OF NIH.—

24                   “(A) RESPONSIBILITIES OF THE BOARD.—

1                   “(i) IN GENERAL.—The Board shall  
2                   advise, and provide recommendations to,  
3                   the Director of NIH with respect to—

4                               “(I) policies, programs, and pro-  
5                               cedures for carrying out the duties of  
6                               the Director of NIH under this sec-  
7                               tion; and

8                               “(II) significant barriers to suc-  
9                               cessful translation of basic science  
10                              into clinical application (including  
11                              issues under the purview of other  
12                              agencies and departments).

13                   “(ii) REPORT.—In the case that the  
14                   Board identifies a significant barrier, as  
15                   described in clause (i)(II), the Board shall  
16                   submit to the Secretary a report regarding  
17                   such barrier.

18                   “(B) RESPONSIBILITIES OF THE DIRECTOR  
19                   OF NIH.—With respect to each recommendation  
20                   provided by the Board under subparagraph  
21                   (A)(i), the Director of NIH shall respond in  
22                   writing to the Board, indicating whether such  
23                   Director will implement such recommendation.  
24                   In the case that the Director of NIH indicates  
25                   a recommendation of the Board will not be im-

1           plemented, such Director shall provide an expla-  
2           nation of the reasons for not implementing such  
3           recommendation.

4           “(5) MEETINGS.—

5                 “(A) IN GENERAL.—The Board shall meet  
6           4 times per calendar year, at the call of the  
7           Chairperson.

8                 “(B) QUORUM; REQUIREMENTS; LIMITA-  
9           TIONS.—

10                 “(i) QUORUM.—A quorum shall con-  
11           sist of a total of 13 members of the Board,  
12           excluding ex-officio members, with diverse  
13           representation as described in clause (iii).

14                 “(ii) CHAIRPERSON OR VICE CHAIR-  
15           PERSON.—Each meeting of the Board shall  
16           be attended by either the Chairperson or  
17           the Vice Chairperson.

18                 “(iii) DIVERSE REPRESENTATION.—  
19           At each meeting of the Board, there shall  
20           be not less than one scientist, one rep-  
21           resentative of a disease advocacy organiza-  
22           tion, and one representative of a profes-  
23           sional venture capital or private equity or-  
24           ganization.

1           “(6) COMPENSATION AND TRAVEL EX-  
2 PENSES.—

3           “(A) COMPENSATION.—Members shall re-  
4 ceive compensation at a rate to be fixed by the  
5 Chairperson but not to exceed a rate equal to  
6 the daily equivalent of the annual rate of basic  
7 pay prescribed for level IV of the Executive  
8 Schedule under section 5315 of title 5, United  
9 States Code, for each day (including travel  
10 time) during which the member is engaged in  
11 the performance of the duties of the Board. All  
12 members of the Board who are officers or em-  
13 ployees of the United States shall serve without  
14 compensation in addition to that received for  
15 their services as officers or employees of the  
16 United States.

17           “(B) TRAVEL EXPENSES.—Members of the  
18 Board shall be allowed travel expenses, includ-  
19 ing per diem in lieu of subsistence, at rates au-  
20 thorized for persons employed intermittently by  
21 the Federal Government under section 5703(b)  
22 of title 5, United States Code, while away from  
23 their homes or regular places of business in the  
24 performance of services for the Board.

25           “(e) GRANT PROGRAM.—

1           “(1) SUPPORTING INNOVATION.—To carry out  
2 the purposes described in this section, the Director  
3 of NIH shall award contracts, grants, or cooperative  
4 agreements to the entities described in paragraph  
5 (2), to—

6           “(A) promote innovation in technologies  
7 supporting the advanced research and develop-  
8 ment and production of high need cures, includ-  
9 ing through the development of medical prod-  
10 ucts and behavioral therapies.

11           “(B) accelerate the development of high  
12 need cures, including through the development  
13 of medical products, behavioral therapies, and  
14 biomarkers that demonstrate the safety or ef-  
15 fectiveness of medical products; or

16           “(C) help the award recipient establish  
17 protocols that comply with Food and Drug Ad-  
18 ministration standards and otherwise permit  
19 the recipient to meet regulatory requirements at  
20 all stages of development, manufacturing, re-  
21 view, approval, and safety surveillance of a  
22 medical product.

23           “(2) ELIGIBLE ENTITIES.—To receive assist-  
24 ance under paragraph (1), an entity shall—

1           “(A) be a public or private entity, which  
2           may include a private or public research institu-  
3           tion, an institution of higher education, a med-  
4           ical center, a biotechnology company, a pharma-  
5           ceutical company, a disease advocacy organiza-  
6           tion, a patient advocacy organization, or an  
7           academic research institution;

8           “(B) submit an application containing—

9           “(i) a detailed description of the  
10           project for which the entity seeks such  
11           grant or contract;

12           “(ii) a timetable for such project;

13           “(iii) an assurance that the entity will  
14           submit—

15           “(I) interim reports describing  
16           the entity’s—

17           “(aa) progress in carrying  
18           out the project; and

19           “(bb) compliance with all  
20           provisions of this section and  
21           conditions of receipt of such  
22           grant or contract; and

23           “(II) a final report at the conclu-  
24           sion of the grant period, describing  
25           the outcomes of the project; and

1                   “(iv) a description of the protocols the  
2                   entity will follow to comply with Food and  
3                   Drug Administration standards and regu-  
4                   latory requirements at all stages of devel-  
5                   opment, manufacturing, review, approval,  
6                   and safety surveillance of a medical prod-  
7                   uct; and

8                   “(C) provide such additional information  
9                   as the Director of NIH may require.

10                  “(3) AWARDS.—

11                   “(A) THE CURES ACCELERATION PART-  
12                   NERSHIP AWARDS.—

13                   “(i) INITIAL AWARD AMOUNT.—Each  
14                   award under this subparagraph shall be  
15                   not more than \$15,000,000 per project for  
16                   the first fiscal year for which the project is  
17                   funded, which shall be payable in one pay-  
18                   ment.

19                   “(ii) FUNDING IN SUBSEQUENT FIS-  
20                   CAL YEARS.—An eligible entity receiving  
21                   an award under clause (i) may apply for  
22                   additional funding for such project by sub-  
23                   mitting to the Director of NIH the infor-  
24                   mation required under subparagraphs (B)  
25                   and (C) of paragraph (2). The Director

1           may fund a project of such eligible entity  
2           in an amount not to exceed \$15,000,000  
3           for a fiscal year subsequent to the initial  
4           award under clause (i).

5                   “(iii) MATCHING FUNDS.—As a condi-  
6           tion for receiving an award under this sub-  
7           section, an eligible entity shall contribute  
8           to the project non-Federal funds in the  
9           amount of \$1 for every \$3 awarded under  
10          clauses (i) and (ii), except that the Direc-  
11         tor of NIH may waive or modify such  
12         matching requirement in any case where  
13         the Director determines that the goals and  
14         objectives of this section cannot adequately  
15         be carried out unless such requirement is  
16         waived.

17                   “(B) THE CURES ACCELERATION GRANT  
18         AWARDS.—

19                   “(i) INITIAL AWARD AMOUNT.—Each  
20         award under this subparagraph shall be  
21         not more than \$15,000,000 per project for  
22         the first fiscal year for which the project is  
23         funded, which shall be payable in one pay-  
24         ment.

1                   “(ii) FUNDING IN SUBSEQUENT FIS-  
2                   CAL YEARS.—An eligible entity receiving  
3                   an award under clause (i) may apply for  
4                   additional funding for such project by sub-  
5                   mitting to the Board the information re-  
6                   quired under subparagraphs (B) and (C)  
7                   of paragraph (2). The Director of NIH  
8                   may fund a project of such eligible entity  
9                   in an amount not to exceed \$15,000,000  
10                  for a fiscal year subsequent to the initial  
11                  award under clause (i).

12                  “(C) THE CURES ACCELERATION FLEXI-  
13                  BLE RESEARCH AWARDS.—If the Director of  
14                  NIH determines that the goals and objectives of  
15                  this section cannot adequately be carried out  
16                  through a contract, grant, or cooperative agree-  
17                  ment, the Director of NIH shall have flexible  
18                  research authority to use other transactions to  
19                  fund projects in accordance with the terms and  
20                  conditions of this section. Awards made under  
21                  such flexible research authority for a fiscal year  
22                  shall not exceed 20 percent of the total funds  
23                  appropriated under subsection (g)(1) for such  
24                  fiscal year.

1           “(4) SUSPENSION OF AWARDS FOR DEFAULTS,  
2           NONCOMPLIANCE WITH PROVISIONS AND PLANS,  
3           AND DIVERSION OF FUNDS; REPAYMENT OF  
4           FUNDS.—The Director of NIH may suspend the  
5           award to any entity upon noncompliance by such en-  
6           tity with provisions and plans under this section or  
7           diversion of funds.

8           “(5) AUDITS.—The Director of NIH may enter  
9           into agreements with other entities to conduct peri-  
10          odic audits of the projects funded by grants or con-  
11          tracts awarded under this subsection.

12          “(6) CLOSEOUT PROCEDURES.—At the end of a  
13          grant or contract period, a recipient shall follow the  
14          closeout procedures under section 74.71 of title 45,  
15          Code of Federal Regulations (or any successor regu-  
16          lation).

17          “(7) REVIEW.—A determination by the Direc-  
18          tor of NIH as to whether a drug, device, or biologi-  
19          cal product is a high need cure (for purposes of sub-  
20          section (a)(3)) shall not be subject to judicial review.

21          “(f) COMPETITIVE BASIS OF AWARDS.—Any grant,  
22          cooperative agreement, or contract awarded under this  
23          section shall be awarded on a competitive basis.

24          “(g) AUTHORIZATION OF APPROPRIATIONS.—

1           “(1) IN GENERAL.—For purposes of carrying  
2           out this section, there are authorized to be appro-  
3           priated \$500,000,000 for fiscal year 2010, and such  
4           sums as may be necessary for subsequent fiscal  
5           years. Funds appropriated under this section shall  
6           be available until expended.

7           “(2) LIMITATION ON USE OF FUNDS OTHER-  
8           WISE APPROPRIATED.—No funds appropriated under  
9           this Act, other than funds appropriated under para-  
10          graph (1), may be allocated to the Cures Accelera-  
11          tion Network.”.

12 **SEC. 10410. CENTERS OF EXCELLENCE FOR DEPRESSION.**

13          (a) SHORT TITLE.—This section may be cited as the  
14          “Establishing a Network of Health-Advancing National  
15          Centers of Excellence for Depression Act of 2009” or the  
16          “ENHANCED Act of 2009”.

17          (b) CENTERS OF EXCELLENCE FOR DEPRESSION.—  
18          Subpart 3 of part B of title V of the Public Health Service  
19          Act (42 U.S.C. 290bb et seq.) is amended by inserting  
20          after section 520A the following:

21 **“SEC. 520B. NATIONAL CENTERS OF EXCELLENCE FOR DE-**  
22 **PRESSION.**

23          “(a) DEPRESSIVE DISORDER DEFINED.—In this sec-  
24          tion, the term ‘depressive disorder’ means a mental or

1 brain disorder relating to depression, including major de-  
2 pression, bipolar disorder, and related mood disorders.

3 “(b) GRANT PROGRAM.—

4 “(1) IN GENERAL.—The Secretary, acting  
5 through the Administrator, shall award grants on a  
6 competitive basis to eligible entities to establish na-  
7 tional centers of excellence for depression (referred  
8 to in this section as ‘Centers’), which shall engage  
9 in activities related to the treatment of depressive  
10 disorders.

11 “(2) ALLOCATION OF AWARDS.—If the funds  
12 authorized under subsection (f) are appropriated in  
13 the amounts provided for under such subsection, the  
14 Secretary shall allocate such amounts so that—

15 “(A) not later than 1 year after the date  
16 of enactment of the ENHANCED Act of 2009,  
17 not more than 20 Centers may be established;  
18 and

19 “(B) not later than September 30, 2016,  
20 not more than 30 Centers may be established.

21 “(3) GRANT PERIOD.—

22 “(A) IN GENERAL.—A grant awarded  
23 under this section shall be for a period of 5  
24 years.

1           “(B) RENEWAL.—A grant awarded under  
2           subparagraph (A) may be renewed, on a com-  
3           petitive basis, for 1 additional 5-year period, at  
4           the discretion of the Secretary. In determining  
5           whether to renew a grant, the Secretary shall  
6           consider the report cards issued under sub-  
7           section (e)(2).

8           “(4) USE OF FUNDS.—Grant funds awarded  
9           under this subsection shall be used for the establish-  
10          ment and ongoing activities of the recipient of such  
11          funds.

12          “(5) ELIGIBLE ENTITIES.—

13                 “(A) REQUIREMENTS.—To be eligible to  
14                 receive a grant under this section, an entity  
15                 shall—

16                         “(i) be an institution of higher edu-  
17                         cation or a public or private nonprofit re-  
18                         search institution; and

19                         “(ii) submit an application to the Sec-  
20                         retary at such time and in such manner as  
21                         the Secretary may require, as described in  
22                         subparagraph (B).

23                 “(B) APPLICATION.—An application de-  
24                 scribed in subparagraph (A)(ii) shall include—

25                         “(i) evidence that such entity—

1                   “(I) provides, or is capable of co-  
2                   ordinating with other entities to pro-  
3                   vide, comprehensive health services  
4                   with a focus on mental health services  
5                   and subspecialty expertise for depres-  
6                   sive disorders;

7                   “(II) collaborates with other  
8                   mental health providers, as necessary,  
9                   to address co-occurring mental ill-  
10                  nesses;

11                  “(III) is capable of training  
12                  health professionals about mental  
13                  health; and

14                  “(ii) such other information, as the  
15                  Secretary may require.

16                  “(C) PRIORITIES.—In awarding grants  
17                  under this section, the Secretary shall give pri-  
18                  ority to eligible entities that meet 1 or more of  
19                  the following criteria:

20                  “(i) Demonstrated capacity and exper-  
21                  tise to serve the targeted population.

22                  “(ii) Existing infrastructure or exper-  
23                  tise to provide appropriate, evidence-based  
24                  and culturally and linguistically competent  
25                  services.

1                   “(iii) A location in a geographic area  
2                   with disproportionate numbers of under-  
3                   served and at-risk populations in medically  
4                   underserved areas and health professional  
5                   shortage areas.

6                   “(iv) Proposed innovative approaches  
7                   for outreach to initiate or expand services.

8                   “(v) Use of the most up-to-date  
9                   science, practices, and interventions avail-  
10                  able.

11                  “(vi) Demonstrated capacity to estab-  
12                  lish cooperative and collaborative agree-  
13                  ments with community mental health cen-  
14                  ters and other community entities to pro-  
15                  vide mental health, social, and human serv-  
16                  ices to individuals with depressive dis-  
17                  orders.

18                  “(6) NATIONAL COORDINATING CENTER.—

19                  “(A) IN GENERAL.—The Secretary, acting  
20                  through the Administrator, shall designate 1 re-  
21                  cipient of a grant under this section to be the  
22                  coordinating center of excellence for depression  
23                  (referred to in this section as the ‘coordinating  
24                  center’). The Secretary shall select such coordi-  
25                  nating center on a competitive basis, based

1           upon the demonstrated capacity of such center  
2           to perform the duties described in subpara-  
3           graph (C).

4           “(B) APPLICATION.—A Center that has  
5           been awarded a grant under paragraph (1) may  
6           apply for designation as the coordinating center  
7           by submitting an application to the Secretary at  
8           such time, in such manner, and containing such  
9           information as the Secretary may require.

10          “(C) DUTIES.—The coordinating center  
11          shall—

12                 “(i) develop, administer, and coordi-  
13                 nate the network of Centers under this sec-  
14                 tion;

15                 “(ii) oversee and coordinate the na-  
16                 tional database described in subsection (d);

17                 “(iii) lead a strategy to disseminate  
18                 the findings and activities of the Centers  
19                 through such database; and

20                 “(iv) serve as a liaison with the Ad-  
21                 ministration, the National Registry of Evi-  
22                 dence-based Programs and Practices of the  
23                 Administration, and any Federal inter-  
24                 agency or interagency forum on mental  
25                 health.

1           “(7) MATCHING FUNDS.—The Secretary may  
2 not award a grant or contract under this section to  
3 an entity unless the entity agrees that it will make  
4 available (directly or through contributions from  
5 other public or private entities) non-Federal con-  
6 tributions toward the activities to be carried out  
7 under the grant or contract in an amount equal to  
8 \$1 for each \$5 of Federal funds provided under the  
9 grant or contract. Such non-Federal matching funds  
10 may be provided directly or through donations from  
11 public or private entities and may be in cash or in-  
12 kind, fairly evaluated, including plant, equipment, or  
13 services.

14           “(c) ACTIVITIES OF THE CENTERS.—Each Center  
15 shall carry out the following activities:

16           “(1) GENERAL ACTIVITIES.—Each Center  
17 shall—

18                   “(A) integrate basic, clinical, or health  
19 services interdisciplinary research and practice  
20 in the development, implementation, and dis-  
21 semination of evidence-based interventions;

22                   “(B) involve a broad cross-section of stake-  
23 holders, such as researchers, clinicians, con-  
24 sumers, families of consumers, and voluntary  
25 health organizations, to develop a research

1 agenda and disseminate findings, and to pro-  
2 vide support in the implementation of evidence-  
3 based practices;

4 “(C) provide training and technical assist-  
5 ance to mental health professionals, and engage  
6 in and disseminate translational research with a  
7 focus on meeting the needs of individuals with  
8 depressive disorders; and

9 “(D) educate policy makers, employers,  
10 community leaders, and the public about de-  
11 pressive disorders to reduce stigma and raise  
12 awareness of treatments.

13 “(2) IMPROVED TREATMENT STANDARDS, CLIN-  
14 ICAL GUIDELINES, DIAGNOSTIC PROTOCOLS, AND  
15 CARE COORDINATION PRACTICE.—Each Center shall  
16 collaborate with other Centers in the network to—

17 “(A) develop and implement treatment  
18 standards, clinical guidelines, and protocols that  
19 emphasize primary prevention, early interven-  
20 tion, treatment for, and recovery from, depres-  
21 sive disorders;

22 “(B) foster communication with other pro-  
23 viders attending to co-occurring physical health  
24 conditions such as cardiovascular, diabetes, can-  
25 cer, and substance abuse disorders;

1           “(C) leverage available community re-  
2           sources, develop and implement improved self-  
3           management programs, and, when appropriate,  
4           involve family and other providers of social sup-  
5           port in the development and implementation of  
6           care plans; and

7           “(D) use electronic health records and tele-  
8           health technology to better coordinate and man-  
9           age, and improve access to, care, as determined  
10          by the coordinating center.

11          “(3) TRANSLATIONAL RESEARCH THROUGH  
12          COLLABORATION OF CENTERS AND COMMUNITY-  
13          BASED ORGANIZATIONS.—Each Center shall—

14               “(A) demonstrate effective use of a public-  
15               private partnership to foster collaborations  
16               among members of the network and commu-  
17               nity-based organizations such as community  
18               mental health centers and other social and  
19               human services providers;

20               “(B)           expand           interdisciplinary,  
21               translational, and patient-oriented research and  
22               treatment; and

23               “(C) coordinate with accredited academic  
24               programs to provide ongoing opportunities for

1           the professional and continuing education of  
2           mental health providers.

3           “(d) NATIONAL DATABASE.—

4           “(1) IN GENERAL.—The coordinating center  
5           shall establish and maintain a national, publicly  
6           available database to improve prevention programs,  
7           evidence-based interventions, and disease manage-  
8           ment programs for depressive disorders, using data  
9           collected from the Centers, as described in para-  
10          graph (2).

11          “(2) DATA COLLECTION.—Each Center shall  
12          submit data gathered at such center, as appropriate,  
13          to the coordinating center regarding—

14                  “(A) the prevalence and incidence of de-  
15                  pressive disorders;

16                  “(B) the health and social outcomes of in-  
17                  dividuals with depressive disorders;

18                  “(C) the effectiveness of interventions de-  
19                  signed, tested, and evaluated;

20                  “(D) other information, as the Secretary  
21                  may require.

22          “(3) SUBMISSION OF DATA TO THE ADMINIS-  
23          TRATOR.—The coordinating center shall submit to  
24          the Administrator the data and financial information  
25          gathered under paragraph (2).

1           “(4) PUBLICATION USING DATA FROM THE  
2           DATABASE.—A Center, or an individual affiliated  
3           with a Center, may publish findings using the data  
4           described in paragraph (2) only if such center sub-  
5           mits such data to the coordinating center, as re-  
6           quired under such paragraph.

7           “(e) ESTABLISHMENT OF STANDARDS; REPORT  
8           CARDS AND RECOMMENDATIONS; THIRD PARTY RE-  
9           VIEW.—

10           “(1) ESTABLISHMENT OF STANDARDS.—The  
11           Secretary, acting through the Administrator, shall  
12           establish performance standards for—

13                   “(A) each Center; and

14                   “(B) the network of Centers as a whole.

15           “(2) REPORT CARDS.—The Secretary, acting  
16           through the Administrator, shall—

17                   “(A) for each Center, not later than 3  
18                   years after the date on which such center of ex-  
19                   cellence is established and annually thereafter,  
20                   issue a report card to the coordinating center to  
21                   rate the performance of such Center; and

22                   “(B) not later than 3 years after the date  
23                   on which the first grant is awarded under sub-  
24                   section (b)(1) and annually thereafter, issue a  
25                   report card to Congress to rate the performance

1 of the network of centers of excellence as a  
2 whole.

3 “(3) RECOMMENDATIONS.—Based upon the re-  
4 port cards described in paragraph (2), the Secretary  
5 shall, not later than September 30, 2015—

6 “(A) make recommendations to the Cen-  
7 ters regarding improvements such centers shall  
8 make; and

9 “(B) make recommendations to Congress  
10 for expanding the Centers to serve individuals  
11 with other types of mental disorders.

12 “(4) THIRD PARTY REVIEW.—Not later than 3  
13 years after the date on which the first grant is  
14 awarded under subsection (b)(1) and annually there-  
15 after, the Secretary shall arrange for an independent  
16 third party to conduct an evaluation of the network  
17 of Centers to ensure that such centers are meeting  
18 the goals of this section.

19 “(f) AUTHORIZATION OF APPROPRIATIONS.—

20 “(1) IN GENERAL.—To carry out this section,  
21 there are authorized to be appropriated—

22 “(A) \$100,000,000 for each of the fiscal  
23 years 2011 through 2015; and

24 “(B) \$150,000,000 for each of the fiscal  
25 years 2016 through 2020.

1           “(2) ALLOCATION OF FUNDS AUTHORIZED.—Of  
2           the amount appropriated under paragraph (1) for a  
3           fiscal year, the Secretary shall determine the alloca-  
4           tion of each Center receiving a grant under this sec-  
5           tion, but in no case may the allocation be more than  
6           \$5,000,000, except that the Secretary may allocate  
7           not more than \$10,000,000 to the coordinating cen-  
8           ter.”.

9   **SEC. 10411. PROGRAMS RELATING TO CONGENITAL HEART**  
10                           **DISEASE.**

11           (a) SHORT TITLE.—This subtitle may be cited as the  
12           “Congenital Heart Futures Act”.

13           (b) PROGRAMS RELATING TO CONGENITAL HEART  
14           DISEASE.—

15                   (1) NATIONAL CONGENITAL HEART DISEASE  
16           SURVEILLANCE SYSTEM.—Part P of title III of the  
17           Public Health Service Act (42 U.S.C. 280g et seq.),  
18           as amended by section 5405, is further amended by  
19           adding at the end the following:

20   **“SEC. 399V-2. NATIONAL CONGENITAL HEART DISEASE SUR-**  
21                           **VEILLANCE SYSTEM.**

22           “(a) IN GENERAL.—The Secretary, acting through  
23           the Director of the Centers for Disease Control and Pre-  
24           vention, may—

1           “(1) enhance and expand infrastructure to  
2 track the epidemiology of congenital heart disease  
3 and to organize such information into a nationally-  
4 representative, population-based surveillance system  
5 that compiles data concerning actual occurrences of  
6 congenital heart disease, to be known as the ‘Na-  
7 tional Congenital Heart Disease Surveillance Sys-  
8 tem’; or

9           “(2) award a grant to one eligible entity to un-  
10 dertake the activities described in paragraph (1).

11       “(b) PURPOSE.—The purpose of the Congenital  
12 Heart Disease Surveillance System shall be to facilitate  
13 further research into the types of health services patients  
14 use and to identify possible areas for educational outreach  
15 and prevention in accordance with standard practices of  
16 the Centers for Disease Control and Prevention.

17       “(c) CONTENT.—The Congenital Heart Disease Sur-  
18 veillance System—

19           “(1) may include information concerning the in-  
20 cidence and prevalence of congenital heart disease in  
21 the United States;

22           “(2) may be used to collect and store data on  
23 congenital heart disease, including data con-  
24 cerning—

1           “(A) demographic factors associated with  
2           congenital heart disease, such as age, race, eth-  
3           nicity, sex, and family history of individuals  
4           who are diagnosed with the disease;

5           “(B) risk factors associated with the dis-  
6           ease;

7           “(C) causation of the disease;

8           “(D) treatment approaches; and

9           “(E) outcome measures, such that analysis  
10          of the outcome measures will allow derivation of  
11          evidence-based best practices and guidelines for  
12          congenital heart disease patients; and

13          “(3) may ensure the collection and analysis of  
14          longitudinal data related to individuals of all ages  
15          with congenital heart disease, including infants,  
16          young children, adolescents, and adults of all ages.

17          “(d) PUBLIC ACCESS.—The Congenital Heart Dis-  
18          ease Surveillance System shall be made available to the  
19          public, as appropriate, including congenital heart disease  
20          researchers.

21          “(e) PATIENT PRIVACY.—The Secretary shall ensure  
22          that the Congenital Heart Disease Surveillance System is  
23          maintained in a manner that complies with the regulations  
24          promulgated under section 264 of the Health Insurance  
25          Portability and Accountability Act of 1996.

1       “(f) ELIGIBILITY FOR GRANT.—To be eligible to re-  
2 ceive a grant under subsection (a)(2), an entity shall—

3               “(1) be a public or private nonprofit entity with  
4 specialized experience in congenital heart disease;  
5 and

6               “(2) submit to the Secretary an application at  
7 such time, in such manner, and containing such in-  
8 formation as the Secretary may require.”.

9               (2) CONGENITAL HEART DISEASE RESEARCH.—  
10 Subpart 2 of part C of title IV of the Public Health  
11 Service Act (42 U.S.C. 285b et seq.) is amended by  
12 adding at the end the following:

13 **“SEC. 425. CONGENITAL HEART DISEASE.**

14       “(a) IN GENERAL.—The Director of the Institute  
15 may expand, intensify, and coordinate research and re-  
16 lated activities of the Institute with respect to congenital  
17 heart disease, which may include congenital heart disease  
18 research with respect to—

19               “(1) causation of congenital heart disease, in-  
20 cluding genetic causes;

21               “(2) long-term outcomes in individuals with  
22 congenital heart disease, including infants, children,  
23 teenagers, adults, and elderly individuals;

24               “(3) diagnosis, treatment, and prevention;



1       tion that has substantial expertise in pediatric edu-  
2       cation, pediatric medicine, and electrophysiology and  
3       sudden death,”; and

4               (2) in the first sentence of subsection (e), by  
5       striking “fiscal year 2003” and all that follows  
6       through “2006” and inserting “for each of fiscal  
7       years 2003 through 2014”.

8       **SEC. 10413. YOUNG WOMEN’S BREAST HEALTH AWARENESS**  
9                       **AND SUPPORT OF YOUNG WOMEN DIAG-**  
10                      **NOSED WITH BREAST CANCER.**

11       (a) **SHORT TITLE.**—This section may be cited as the  
12       “Young Women’s Breast Health Education and Aware-  
13       ness Requires Learning Young Act of 2009” or the  
14       “EARLY Act”.

15       (b) **AMENDMENT.**—Title III of the Public Health  
16       Service Act (42 U.S.C. 241 et seq.), as amended by this  
17       Act, is further amended by adding at the end the fol-  
18       lowing:

19               **“PART V—PROGRAMS RELATING TO BREAST**  
20                      **HEALTH AND CANCER**  
21       **“SEC. 399NN. YOUNG WOMEN’S BREAST HEALTH AWARE-**  
22                      **NESS AND SUPPORT OF YOUNG WOMEN DIAG-**  
23                      **NOSED WITH BREAST CANCER.**

24       “(a) **PUBLIC EDUCATION CAMPAIGN.**—

1           “(1) IN GENERAL.—The Secretary, acting  
2 through the Director of the Centers for Disease  
3 Control and Prevention, shall conduct a national evi-  
4 dence-based education campaign to increase aware-  
5 ness of young women’s knowledge regarding—

6           “(A) breast health in young women of all  
7 racial, ethnic, and cultural backgrounds;

8           “(B) breast awareness and good breast  
9 health habits;

10           “(C) the occurrence of breast cancer and  
11 the general and specific risk factors in women  
12 who may be at high risk for breast cancer based  
13 on familial, racial, ethnic, and cultural back-  
14 grounds such as Ashkenazi Jewish populations;

15           “(D) evidence-based information that  
16 would encourage young women and their health  
17 care professional to increase early detection of  
18 breast cancers; and

19           “(E) the availability of health information  
20 and other resources for young women diagnosed  
21 with breast cancer.

22           “(2) EVIDENCE-BASED, AGE APPROPRIATE MES-  
23 SAGES.—The campaign shall provide evidence-based,  
24 age-appropriate messages and materials as developed  
25 by the Centers for Disease Control and Prevention

1 and the Advisory Committee established under para-  
2 graph (4).

3 “(3) MEDIA CAMPAIGN.—In conducting the  
4 education campaign under paragraph (1), the Sec-  
5 retary shall award grants to entities to establish na-  
6 tional multimedia campaigns oriented to young  
7 women that may include advertising through tele-  
8 vision, radio, print media, billboards, posters, all  
9 forms of existing and especially emerging social net-  
10 working media, other Internet media, and any other  
11 medium determined appropriate by the Secretary.

12 “(4) ADVISORY COMMITTEE.—

13 “(A) ESTABLISHMENT.—Not later than 60  
14 days after the date of the enactment of this sec-  
15 tion, the Secretary, acting through the Director  
16 of the Centers for Disease Control and Preven-  
17 tion, shall establish an advisory committee to  
18 assist in creating and conducting the education  
19 campaigns under paragraph (1) and subsection  
20 (b)(1).

21 “(B) MEMBERSHIP.—The Secretary, act-  
22 ing through the Director of the Centers for Dis-  
23 ease Control and Prevention, shall appoint to  
24 the advisory committee under subparagraph (A)  
25 such members as deemed necessary to properly

1           advise the Secretary, and shall include organi-  
2           zations and individuals with expertise in breast  
3           cancer, disease prevention, early detection, diag-  
4           nosis, public health, social marketing, genetic  
5           screening and counseling, treatment, rehabilita-  
6           tion, palliative care, and survivorship in young  
7           women.

8           “(b) HEALTH CARE PROFESSIONAL EDUCATION  
9           CAMPAIGN.—The Secretary, acting through the Director  
10          of the Centers for Disease Control and Prevention, and  
11          in consultation with the Administrator of the Health Re-  
12          sources and Services Administration, shall conduct an  
13          education campaign among physicians and other health  
14          care professionals to increase awareness—

15                 “(1) of breast health, symptoms, and early di-  
16                 agnosis and treatment of breast cancer in young  
17                 women, including specific risk factors such as family  
18                 history of cancer and women that may be at high  
19                 risk for breast cancer, such as Ashkenazi Jewish  
20                 population;

21                 “(2) on how to provide counseling to young  
22                 women about their breast health, including knowl-  
23                 edge of their family cancer history and importance  
24                 of providing regular clinical breast examinations;

1           “(3) concerning the importance of discussing  
2           healthy behaviors, and increasing awareness of serv-  
3           ices and programs available to address overall health  
4           and wellness, and making patient referrals to ad-  
5           dress tobacco cessation, good nutrition, and physical  
6           activity;

7           “(4) on when to refer patients to a health care  
8           provider with genetics expertise;

9           “(5) on how to provide counseling that address-  
10          es long-term survivorship and health concerns of  
11          young women diagnosed with breast cancer; and

12          “(6) on when to provide referrals to organiza-  
13          tions and institutions that provide credible health in-  
14          formation and substantive assistance and support to  
15          young women diagnosed with breast cancer.

16          “(c) PREVENTION RESEARCH ACTIVITIES.—The Sec-  
17          retary, acting through—

18                 “(1) the Director of the Centers for Disease  
19                 Control and Prevention, shall conduct prevention re-  
20                 search on breast cancer in younger women, includ-  
21                 ing—

22                         “(A) behavioral, survivorship studies, and  
23                         other research on the impact of breast cancer  
24                         diagnosis on young women;

1           “(B) formative research to assist with the  
2           development of educational messages and infor-  
3           mation for the public, targeted populations, and  
4           their families about breast health, breast can-  
5           cer, and healthy lifestyles;

6           “(C) testing and evaluating existing and  
7           new social marketing strategies targeted at  
8           young women; and

9           “(D) surveys of health care providers and  
10          the public regarding knowledge, attitudes, and  
11          practices related to breast health and breast  
12          cancer prevention and control in high-risk popu-  
13          lations; and

14          “(2) the Director of the National Institutes of  
15          Health, shall conduct research to develop and vali-  
16          date new screening tests and methods for prevention  
17          and early detection of breast cancer in young  
18          women.

19          “(d) SUPPORT FOR YOUNG WOMEN DIAGNOSED  
20 WITH BREAST CANCER.—

21           “(1) IN GENERAL.—The Secretary shall award  
22           grants to organizations and institutions to provide  
23           health information from credible sources and sub-  
24           stantive assistance directed to young women diag-

1 nosed with breast cancer and pre-neoplastic breast  
2 diseases.

3 “(2) PRIORITY.—In making grants under para-  
4 graph (1), the Secretary shall give priority to appli-  
5 cants that deal specifically with young women diag-  
6 nosed with breast cancer and pre-neoplastic breast  
7 disease.

8 “(e) NO DUPLICATION OF EFFORT.—In conducting  
9 an education campaign or other program under sub-  
10 sections (a), (b), (c), or (d), the Secretary shall avoid du-  
11 plicating other existing Federal breast cancer education  
12 efforts.

13 “(f) MEASUREMENT; REPORTING.—The Secretary,  
14 acting through the Director of the Centers for Disease  
15 Control and Prevention, shall—

16 “(1) measure—

17 “(A) young women’s awareness regarding  
18 breast health, including knowledge of family  
19 cancer history, specific risk factors and early  
20 warning signs, and young women’s proactive ef-  
21 forts at early detection;

22 “(B) the number or percentage of young  
23 women utilizing information regarding lifestyle  
24 interventions that foster healthy behaviors;

1           “(C) the number or percentage of young  
2           women receiving regular clinical breast exams;  
3           and

4           “(D) the number or percentage of young  
5           women who perform breast self exams, and the  
6           frequency of such exams, before the implemen-  
7           tation of this section;

8           “(2) not less than every 3 years, measure the  
9           impact of such activities; and

10           “(3) submit reports to the Congress on the re-  
11           sults of such measurements.

12           “(g) DEFINITION.—In this section, the term ‘young  
13           women’ means women 15 to 44 years of age.

14           “(h) AUTHORIZATION OF APPROPRIATIONS.—To  
15           carry out subsections (a), (b), (c)(1), and (d), there are  
16           authorized to be appropriated \$9,000,000 for each of the  
17           fiscal years 2010 through 2014.”.

18           **Subtitle E—Provisions Relating to**  
19           **Title V**

20           **SEC. 10501. AMENDMENTS TO THE PUBLIC HEALTH SERV-**  
21           **ICE ACT, THE SOCIAL SECURITY ACT, AND**  
22           **TITLE V OF THIS ACT.**

23           (a) Section 5101 of this Act is amended—

1           (1) in subsection (c)(2)(B)(i)(II), by inserting  
2           “, including representatives of small business and  
3           self-employed individuals” after “employers”;

4           (2) in subsection (d)(4)(A)—

5                 (A) by redesignating clause (iv) as clause  
6                 (v); and

7                 (B) by inserting after clause (iii) the fol-  
8           lowing:

9                         “(iv) An analysis of, and rec-  
10                         ommendations for, eliminating the barriers  
11                         to entering and staying in primary care,  
12                         including provider compensation.”; and

13           (3) in subsection (i)(2)(B), by inserting “op-  
14           tometrists, ophthalmologists,” after “occupational  
15           therapists,”.

16           (b) Subtitle B of title V of this Act is amended by  
17           adding at the end the following:

18           **“SEC. 5104. INTERAGENCY TASK FORCE TO ASSESS AND IM-**  
19                                 **PROVE ACCESS TO HEALTH CARE IN THE**  
20                                 **STATE OF ALASKA.**

21           “(a) **ESTABLISHMENT.**—There is established a task  
22           force to be known as the ‘Interagency Access to Health  
23           Care in Alaska Task Force’ (referred to in this section  
24           as the ‘Task Force’).

25           “(b) **DUTIES.**—The Task Force shall—

1           “(1) assess access to health care for bene-  
2           ficiaries of Federal health care systems in Alaska;  
3           and

4           “(2) develop a strategy for the Federal Govern-  
5           ment to improve delivery of health care to Federal  
6           beneficiaries in the State of Alaska.

7           “(c) MEMBERSHIP.—The Task Force shall be com-  
8           prised of Federal members who shall be appointed, not  
9           later than 45 days after the date of enactment of this Act,  
10          as follows:

11           “(1) The Secretary of Health and Human Serv-  
12           ices shall appoint one representative of each of the  
13           following:

14           “(A) The Department of Health and  
15           Human Services.

16           “(B) The Centers for Medicare and Med-  
17           icaid Services.

18           “(C) The Indian Health Service.

19           “(2) The Secretary of Defense shall appoint one  
20           representative of the TRICARE Management Activ-  
21           ity.

22           “(3) The Secretary of the Army shall appoint  
23           one representative of the Army Medical Department.

24           “(4) The Secretary of the Air Force shall ap-  
25           point one representative of the Air Force, from

1 among officers at the Air Force performing medical  
2 service functions.

3 “(5) The Secretary of Veterans Affairs shall ap-  
4 point one representative of each of the following:

5 “(A) The Department of Veterans Affairs.

6 “(B) The Veterans Health Administration.

7 “(6) The Secretary of Homeland Security shall  
8 appoint one representative of the United States  
9 Coast Guard.

10 “(d) CHAIRPERSON.—One chairperson of the Task  
11 Force shall be appointed by the Secretary at the time of  
12 appointment of members under subsection (c), selected  
13 from among the members appointed under paragraph (1).

14 “(e) MEETINGS.—The Task Force shall meet at the  
15 call of the chairperson.

16 “(f) REPORT.—Not later than 180 days after the  
17 date of enactment of this Act, the Task Force shall submit  
18 to Congress a report detailing the activities of the Task  
19 Force and containing the findings, strategies, rec-  
20 ommendations, policies, and initiatives developed pursuant  
21 to the duty described in subsection (b)(2). In preparing  
22 such report, the Task Force shall consider completed and  
23 ongoing efforts by Federal agencies to improve access to  
24 health care in the State of Alaska.

1 “(g) TERMINATION.—The Task Force shall be termi-  
2 nated on the date of submission of the report described  
3 in subsection (f).”.

4 (c) Section 399V of the Public Health Service Act,  
5 as added by section 5313, is amended—

6 (1) in subsection (b)(4), by striking “identify,  
7 educate, refer, and enroll” and inserting “identify  
8 and refer”; and

9 (2) in subsection (k)(1), by striking “, as de-  
10 fined by the Department of Labor as Standard Oc-  
11 cupational Classification [21–1094]”.

12 (d) Section 738(a)(3) of the Public Health Service  
13 Act (42 U.S.C. 293b(a)(3)) is amended by inserting  
14 “schools offering physician assistant education programs,”  
15 after “public health,”.

16 (e) Subtitle D of title V of this Act is amended by  
17 adding at the end the following:

18 **“SEC. 5316. DEMONSTRATION GRANTS FOR FAMILY NURSE**

19 **PRACTITIONER TRAINING PROGRAMS.**

20 “(a) ESTABLISHMENT OF PROGRAM.—The Secretary  
21 of Health and Human Services (referred to in this section  
22 as the ‘Secretary’) shall establish a training demonstration  
23 program for family nurse practitioners (referred to in this  
24 section as the ‘program’) to employ and provide 1-year  
25 training for nurse practitioners who have graduated from

1 a nurse practitioner program for careers as primary care  
2 providers in Federally qualified health centers (referred to  
3 in this section as ‘FQHCs’) and nurse-managed health  
4 clinics (referred to in this section as ‘NMHCs’).

5 “(b) PURPOSE.—The purpose of the program is to  
6 enable each grant recipient to—

7 “(1) provide new nurse practitioners with clin-  
8 ical training to enable them to serve as primary care  
9 providers in FQHCs and NMHCs;

10 “(2) train new nurse practitioners to work  
11 under a model of primary care that is consistent  
12 with the principles set forth by the Institute of Med-  
13 icine and the needs of vulnerable populations; and

14 “(3) create a model of FQHC and NMHC  
15 training for nurse practitioners that may be rep-  
16 licated nationwide.

17 “(c) GRANTS.—The Secretary shall award 3-year  
18 grants to eligible entities that meet the requirements es-  
19 tablished by the Secretary, for the purpose of operating  
20 the nurse practitioner primary care programs described in  
21 subsection (a) in such entities.

22 “(d) ELIGIBLE ENTITIES.—To be eligible to receive  
23 a grant under this section, an entity shall—

1           “(1)(A) be a FQHC as defined in section  
2           1861(aa) of the Social Security Act (42 U.S.C.  
3           1395x(aa)); or

4           “(B) be a nurse-managed health clinic, as de-  
5           fined in section 330A-1 of the Public Health Service  
6           Act (as added by section 5208 of this Act); and

7           “(2) submit to the Secretary an application at  
8           such time, in such manner, and containing such in-  
9           formation as the Secretary may require.

10          “(e) PRIORITY IN AWARDING GRANTS.—In awarding  
11         grants under this section, the Secretary shall give priority  
12         to eligible entities that—

13           “(1) demonstrate sufficient infrastructure in  
14           size, scope, and capacity to undertake the requisite  
15           training of a minimum of 3 nurse practitioners per  
16           year, and to provide to each awardee 12 full months  
17           of full-time, paid employment and benefits consistent  
18           with the benefits offered to other full-time employees  
19           of such entity;

20           “(2) will assign not less than 1 staff nurse  
21           practitioner or physician to each of 4 precepted clin-  
22           ics;

23           “(3) will provide to each awardee specialty rota-  
24           tions, including specialty training in prenatal care  
25           and women’s health, adult and child psychiatry, or-

1 thopedics, geriatrics, and at least 3 other high-vol-  
2 ume, high-burden specialty areas;

3 “(4) provide sessions on high-volume, high-risk  
4 health problems and have a record of training health  
5 care professionals in the care of children, older  
6 adults, and underserved populations; and

7 “(5) collaborate with other safety net providers,  
8 schools, colleges, and universities that provide health  
9 professions training.

10 “(f) ELIGIBILITY OF NURSE PRACTITIONERS.—

11 “(1) IN GENERAL.—To be eligible for accept-  
12 ance to a program funded through a grant awarded  
13 under this section, an individual shall—

14 “(A) be licensed or eligible for licensure in  
15 the State in which the program is located as an  
16 advanced practice registered nurse or advanced  
17 practice nurse and be eligible or board-certified  
18 as a family nurse practitioner; and

19 “(B) demonstrate commitment to a career  
20 as a primary care provider in a FQHC or in a  
21 NMHC.

22 “(2) PREFERENCE.—In selecting awardees  
23 under the program, each grant recipient shall give  
24 preference to bilingual candidates that meet the re-  
25 quirements described in paragraph (1).

1           “(3) DEFERRAL OF CERTAIN SERVICE.—The  
2           starting date of required service of individuals in the  
3           National Health Service Corps Service program  
4           under title II of the Public Health Service Act (42  
5           U.S.C. 202 et seq.) who receive training under this  
6           section shall be deferred until the date that is 22  
7           days after the date of completion of the program.

8           “(g) GRANT AMOUNT.—Each grant awarded under  
9           this section shall be in an amount not to exceed \$600,000  
10          per year. A grant recipient may carry over funds from 1  
11          fiscal year to another without obtaining approval from the  
12          Secretary.

13          “(h) TECHNICAL ASSISTANCE GRANTS.—The Sec-  
14          retary may award technical assistance grants to 1 or more  
15          FQHCs or NMHCs that have demonstrated expertise in  
16          establishing a nurse practitioner residency training pro-  
17          gram. Such technical assistance grants shall be for the  
18          purpose of providing technical assistance to other recipi-  
19          ents of grants under subsection (e).

20          “(i) AUTHORIZATION OF APPROPRIATIONS.—To  
21          carry out this section, there is authorized to be appro-  
22          priated such sums as may be necessary for each of fiscal  
23          years 2011 through 2014.”.

1 (f)(1) Section 399W of the Public Health Service Act,  
2 as added by section 5405, is redesignated as section  
3 399V-1.

4 (2) Section 399V-1 of the Public Health Service Act,  
5 as so redesignated, is amended in subsection (b)(2)(A) by  
6 striking “and the departments of 1 or more health profes-  
7 sions schools in the State that train providers in primary  
8 care” and inserting “and the departments that train pro-  
9 viders in primary care in 1 or more health professions  
10 schools in the State”.

11 (3) Section 934 of the Public Health Service Act, as  
12 added by section 3501, is amended by striking “399W”  
13 each place such term appears and inserting “399V-1”.

14 (4) Section 935(b) of the Public Health Service Act,  
15 as added by section 3503, is amended by striking “399W”  
16 and inserting “399V-1”.

17 (g) Part P of title III of the Public Health Service  
18 Act 42 U.S.C. 280g et seq.), as amended by section  
19 10411, is amended by adding at the end the following:  
20 **“SEC. 399V-3. NATIONAL DIABETES PREVENTION PROGRAM.**

21 “(a) IN GENERAL.—The Secretary, acting through  
22 the Director of the Centers for Disease Control and Pre-  
23 vention, shall establish a national diabetes prevention pro-  
24 gram (referred to in this section as the ‘program’) tar-

1 geted at adults at high risk for diabetes in order to elimi-  
2 nate the preventable burden of diabetes.

3 “(b) PROGRAM ACTIVITIES.—The program described  
4 in subsection (a) shall include—

5 “(1) a grant program for community-based dia-  
6 betes prevention program model sites;

7 “(2) a program within the Centers for Disease  
8 Control and Prevention to determine eligibility of en-  
9 tities to deliver community-based diabetes prevention  
10 services;

11 “(3) a training and outreach program for life-  
12 style intervention instructors; and

13 “(4) evaluation, monitoring and technical as-  
14 sistance, and applied research carried out by the  
15 Centers for Disease Control and Prevention.

16 “(c) ELIGIBLE ENTITIES.—To be eligible for a grant  
17 under subsection (b)(1), an entity shall be a State or local  
18 health department, a tribal organization, a national net-  
19 work of community-based non-profits focused on health  
20 and wellbeing, an academic institution, or other entity, as  
21 the Secretary determines.

22 “(d) AUTHORIZATION OF APPROPRIATIONS.—For the  
23 purpose of carrying out this section, there are authorized  
24 to be appropriated such sums as may be necessary for  
25 each of fiscal years 2010 through 2014.”.

1 (h) The provisions of, and amendment made by, sec-  
2 tion 5501(c) of this Act are repealed.

3 (i)(1) The provisions of, and amendments made by,  
4 section 5502 of this Act are repealed.

5 (2)(A) Section 1861(aa)(3)(A) of the Social Security  
6 Act (42 U.S.C. 1395w(aa)(3)(A)) is amended to read as  
7 follows:

8 “(A) services of the type described in subpara-  
9 graphs (A) through (C) of paragraph (1) and pre-  
10 ventive services (as defined in section 1861(ddd)(3));  
11 and”.

12 (B) The amendment made by subparagraph (A) shall  
13 apply to services furnished on or after January 1, 2011.

14 (3)(A) Section 1834 of the Social Security Act (42  
15 U.S.C. 1395m), as amended by section 4105, is amended  
16 by adding at the end the following new subsection:

17 “(o) DEVELOPMENT AND IMPLEMENTATION OF PRO-  
18 SPECTIVE PAYMENT SYSTEM.—

19 “(1) DEVELOPMENT.—

20 “(A) IN GENERAL.—The Secretary shall  
21 develop a prospective payment system for pay-  
22 ment for Federally qualified health center serv-  
23 ices furnished by Federally qualified health cen-  
24 ters under this title. Such system shall include  
25 a process for appropriately describing the serv-

1           ices furnished by Federally qualified health cen-  
2           ters and shall establish payment rates for spe-  
3           cific payment codes based on such appropriate  
4           descriptions of services. Such system shall be  
5           established to take into account the type, inten-  
6           sity, and duration of services furnished by Fed-  
7           erally qualified health centers. Such system may  
8           include adjustments, including geographic ad-  
9           justments, determined appropriate by the Sec-  
10          retary.

11           “(B) COLLECTION OF DATA AND EVALUA-  
12          TION.—By not later than January 1, 2011, the  
13          Secretary shall require Federally qualified  
14          health centers to submit to the Secretary such  
15          information as the Secretary may require in  
16          order to develop and implement the prospective  
17          payment system under this subsection, includ-  
18          ing the reporting of services using HCPCS  
19          codes.

20          “(2) IMPLEMENTATION.—

21           “(A) IN GENERAL.—Notwithstanding sec-  
22          tion 1833(a)(3)(A), the Secretary shall provide,  
23          for cost reporting periods beginning on or after  
24          October 1, 2014, for payments of prospective  
25          payment rates for Federally qualified health

1 center services furnished by Federally qualified  
2 health centers under this title in accordance  
3 with the prospective payment system developed  
4 by the Secretary under paragraph (1).

5 “(B) PAYMENTS.—

6 “(i) INITIAL PAYMENTS.—The Sec-  
7 retary shall implement such prospective  
8 payment system so that the estimated ag-  
9 gregate amount of prospective payment  
10 rates (determined prior to the application  
11 of section 1833(a)(1)(Z)) under this title  
12 for Federally qualified health center serv-  
13 ices in the first year that such system is  
14 implemented is equal to 100 percent of the  
15 estimated amount of reasonable costs (de-  
16 termined without the application of a per  
17 visit payment limit or productivity screen  
18 and prior to the application of section  
19 1866(a)(2)(A)(ii)) that would have oc-  
20 curred for such services under this title in  
21 such year if the system had not been im-  
22 plemented.

23 “(ii) PAYMENTS IN SUBSEQUENT  
24 YEARS.—Payment rates in years after the  
25 year of implementation of such system

1 shall be the payment rates in the previous  
2 year increased—

3 “(I) in the first year after imple-  
4 mentation of such system, by the per-  
5 centage increase in the MEI (as de-  
6 fined in section 1842(i)(3)) for the  
7 year involved; and

8 “(II) in subsequent years, by the  
9 percentage increase in a market bas-  
10 ket of Federally qualified health cen-  
11 ter goods and services as promulgated  
12 through regulations, or if such an  
13 index is not available, by the percent-  
14 age increase in the MEI (as defined in  
15 section 1842(i)(3)) for the year in-  
16 volved.

17 “(C) PREPARATION FOR PPS IMPLEMENTA-  
18 TION.—Notwithstanding any other provision of  
19 law, the Secretary may establish and implement  
20 by program instruction or otherwise the pay-  
21 ment codes to be used under the prospective  
22 payment system under this section.”.

23 (B) Section 1833(a)(1) of the Social Security Act (42  
24 U.S.C. 1395l(a)(1)), as amended by section 4104, is  
25 amended—

1 (i) by striking “and” before “(Y)”; and

2 (ii) by inserting before the semicolon at the end  
3 the following: “, and (Z) with respect to Federally  
4 qualified health center services for which payment is  
5 made under section 1834(o), the amounts paid shall  
6 be 80 percent of the lesser of the actual charge or  
7 the amount determined under such section”.

8 (C) Section 1833(a) of the Social Security Act (42  
9 U.S.C. 1395l(a)) is amended—

10 (i) in paragraph (3)(B)(i)—

11 (I) by inserting “(I)” after “otherwise been  
12 provided”; and

13 (II) by inserting “, or (II) in the case of  
14 such services furnished on or after the imple-  
15 mentation date of the prospective payment sys-  
16 tem under section 1834(o), under such section  
17 (calculated as if ‘100 percent’ were substituted  
18 for ‘80 percent’ in such section) for such serv-  
19 ices if the individual had not been so enrolled”  
20 after “been so enrolled”; and

21 (ii) by adding at the end the following flush  
22 sentence:

23 “Paragraph (3)(A) shall not apply to Federally  
24 qualified health center services furnished on or after

1 the implementation date of the prospective payment  
2 system under section 1834(0).”.

3 (j) Section 5505 is amended by adding at the end  
4 the following new subsection:

5 “(d) APPLICATION.—The amendments made by this  
6 section shall not be applied in a manner that requires re-  
7 opening of any settled cost reports as to which there is  
8 not a jurisdictionally proper appeal pending as of the date  
9 of the enactment of this Act on the issue of payment for  
10 indirect costs of medical education under section  
11 1886(d)(5)(B) of the Social Security Act (42 U.S.C.  
12 1395ww(d)(5)(B)) or for direct graduate medical edu-  
13 cation costs under section 1886(h) of such Act (42 U.S.C.  
14 1395ww(h)).”.

15 (k) Subtitle G of title V of this Act is amended by  
16 adding at the end the following:

17 **“SEC. 5606. STATE GRANTS TO HEALTH CARE PROVIDERS**  
18 **WHO PROVIDE SERVICES TO A HIGH PER-**  
19 **CENTAGE OF MEDICALLY UNDERSERVED**  
20 **POPULATIONS OR OTHER SPECIAL POPU-**  
21 **LATIONS.**

22 “(a) IN GENERAL.—A State may award grants to  
23 health care providers who treat a high percentage, as de-  
24 termined by such State, of medically underserved popu-  
25 lations or other special populations in such State.

1           “(b) SOURCE OF FUNDS.—A grant program estab-  
2 lished by a State under subsection (a) may not be estab-  
3 lished within a department, agency, or other entity of such  
4 State that administers the Medicaid program under title  
5 XIX of the Social Security Act (42 U.S.C. 1396 et seq.),  
6 and no Federal or State funds allocated to such Medicaid  
7 program, the Medicare program under title XVIII of the  
8 Social Security Act (42 U.S.C. 1395 et seq.), or the  
9 TRICARE program under chapter 55 of title 10, United  
10 States Code, may be used to award grants or to pay ad-  
11 ministrative costs associated with a grant program estab-  
12 lished under subsection (a).”.

13           (l) Part C of title VII of the Public Health Service  
14 Act (42 U.S.C. 293k et seq.) is amended—

15                 (1) after the part heading, by inserting the fol-  
16                 lowing:

17                 **“Subpart I—Medical Training Generally”;**

18                 and

19                 (2) by inserting at the end the following:

20                 **“Subpart II—Training in Underserved Communities**

21                 **“SEC. 749B. RURAL PHYSICIAN TRAINING GRANTS.**

22                 “(a) IN GENERAL.—The Secretary, acting through  
23 the Administrator of the Health Resources and Services  
24 Administration, shall establish a grant program for the  
25 purposes of assisting eligible entities in recruiting students

1 most likely to practice medicine in underserved rural com-  
2 munities, providing rural-focused training and experience,  
3 and increasing the number of recent allopathic and osteo-  
4 pathic medical school graduates who practice in under-  
5 served rural communities.

6 “(b) ELIGIBLE ENTITIES.—In order to be eligible to  
7 receive a grant under this section, an entity shall—

8 “(1) be a school of allopathic or osteopathic  
9 medicine accredited by a nationally recognized ac-  
10 crediting agency or association approved by the Sec-  
11 retary for this purpose, or any combination or con-  
12 sortium of such schools; and

13 “(2) submit an application to the Secretary that  
14 includes a certification that such entity will use  
15 amounts provided to the institution as described in  
16 subsection (d)(1).

17 “(c) PRIORITY.—In awarding grant funds under this  
18 section, the Secretary shall give priority to eligible entities  
19 that—

20 “(1) demonstrate a record of successfully train-  
21 ing students, as determined by the Secretary, who  
22 practice medicine in underserved rural communities;

23 “(2) demonstrate that an existing academic  
24 program of the eligible entity produces a high per-  
25 centage, as determined by the Secretary, of grad-

1 uates from such program who practice medicine in  
2 underserved rural communities;

3 “(3) demonstrate rural community institutional  
4 partnerships, through such mechanisms as matching  
5 or contributory funding, documented in-kind services  
6 for implementation, or existence of training partners  
7 with interprofessional expertise in community health  
8 center training locations or other similar facilities; or

9 “(4) submit, as part of the application of the  
10 entity under subsection (b), a plan for the long-term  
11 tracking of where the graduates of such entity prac-  
12 tice medicine.

13 “(d) USE OF FUNDS.—

14 “(1) ESTABLISHMENT.—An eligible entity re-  
15 ceiving a grant under this section shall use the funds  
16 made available under such grant to establish, im-  
17 prove, or expand a rural-focused training program  
18 (referred to in this section as the ‘Program’) meet-  
19 ing the requirements described in this subsection  
20 and to carry out such program.

21 “(2) STRUCTURE OF PROGRAM.—An eligible en-  
22 tity shall—

23 “(A) enroll no fewer than 10 students per  
24 class year into the Program; and

1                   “(B) develop criteria for admission to the  
2                   Program that gives priority to students—

3                   “(i) who have originated from or lived  
4                   for a period of 2 or more years in an un-  
5                   derserved rural community; and

6                   “(ii) who express a commitment to  
7                   practice medicine in an underserved rural  
8                   community.

9                   “(3) CURRICULA.—The Program shall require  
10                  students to enroll in didactic coursework and clinical  
11                  experience particularly applicable to medical practice  
12                  in underserved rural communities, including—

13                  “(A) clinical rotations in underserved rural  
14                  communities, and in applicable specialties, or  
15                  other coursework or clinical experience deemed  
16                  appropriate by the Secretary; and

17                  “(B) in addition to core school curricula,  
18                  additional coursework or training experiences  
19                  focused on medical issues prevalent in under-  
20                  served rural communities.

21                  “(4) RESIDENCY PLACEMENT ASSISTANCE.—  
22                  Where available, the Program shall assist all stu-  
23                  dents of the Program in obtaining clinical training  
24                  experiences in locations with postgraduate programs  
25                  offering residency training opportunities in under-

1 served rural communities, or in local residency train-  
2 ing programs that support and train physicians to  
3 practice in underserved rural communities.

4 “(5) PROGRAM STUDENT COHORT SUPPORT.—  
5 The Program shall provide and require all students  
6 of the Program to participate in group activities de-  
7 signed to further develop, maintain, and reinforce  
8 the original commitment of such students to practice  
9 in an underserved rural community.

10 “(e) ANNUAL REPORTING.—An eligible entity receiv-  
11 ing a grant under this section shall submit an annual re-  
12 port to the Secretary on the success of the Program, based  
13 on criteria the Secretary determines appropriate, including  
14 the residency program selection of graduating students  
15 who participated in the Program.

16 “(f) REGULATIONS.—Not later than 60 days after  
17 the date of enactment of this section, the Secretary shall  
18 by regulation define ‘underserved rural community’ for  
19 purposes of this section.

20 “(g) SUPPLEMENT NOT SUPPLANT.—Any eligible en-  
21 tity receiving funds under this section shall use such funds  
22 to supplement, not supplant, any other Federal, State, and  
23 local funds that would otherwise be expended by such enti-  
24 ty to carry out the activities described in this section.



1           “(1) an accredited school of public health or  
2 school of medicine or osteopathic medicine;

3           “(2) an accredited public or private nonprofit  
4 hospital;

5           “(3) a State, local, or tribal health department;  
6 or

7           “(4) a consortium of 2 or more entities de-  
8 scribed in paragraphs (1) through (3).

9           “(c) USE OF FUNDS.—Amounts received under a  
10 grant or contract under this section shall be used to—

11           “(1) plan, develop (including the development of  
12 curricula), operate, or participate in an accredited  
13 residency or internship program in preventive medi-  
14 cine or public health;

15           “(2) defray the costs of practicum experiences,  
16 as required in such a program; and

17           “(3) establish, maintain, or improve—

18           “(A) academic administrative units (in-  
19 cluding departments, divisions, or other appro-  
20 priate units) in preventive medicine and public  
21 health; or

22           “(B) programs that improve clinical teach-  
23 ing in preventive medicine and public health.

1       “(d) REPORT.—The Secretary shall submit to the  
2 Congress an annual report on the program carried out  
3 under this section.”.

4           (2) Section 770(a) of the Public Health Service  
5 Act (42 U.S.C. 295e(a)) is amended to read as fol-  
6 lows:

7       “(a) IN GENERAL.—For the purpose of carrying out  
8 this subpart, there is authorized to be appropriated  
9 \$43,000,000 for fiscal year 2011, and such sums as may  
10 be necessary for each of the fiscal years 2012 through  
11 2015.”.

12       (n)(1) Subsection (i) of section 331 of the Public  
13 Health Service Act (42 U.S.C. 254d) of the Public Health  
14 Service Act is amended—

15           (A) in paragraph (1), by striking “In carrying  
16 out subpart III” and all that follows through the pe-  
17 riod and inserting “In carrying out subpart III, the  
18 Secretary may, in accordance with this subsection,  
19 issue waivers to individuals who have entered into a  
20 contract for obligated service under the Scholarship  
21 Program or the Loan Repayment Program under  
22 which the individuals are authorized to satisfy the  
23 requirement of obligated service through providing  
24 clinical practice that is half time.”;

25           (B) in paragraph (2)—

1 (i) in subparagraphs (A)(ii) and (B), by  
2 striking “less than full time” each place it ap-  
3 pears and inserting “half time”;

4 (ii) in subparagraphs (C) and (F), by  
5 striking “less than full-time service” each place  
6 it appears and inserting “half-time service”;  
7 and

8 (iii) by amending subparagraphs (D) and  
9 (E) to read as follows:

10 “(D) the entity and the Corps member agree in  
11 writing that the Corps member will perform half-  
12 time clinical practice;

13 “(E) the Corps member agrees in writing to  
14 fulfill all of the service obligations under section  
15 338C through half-time clinical practice and ei-  
16 ther—

17 “(i) double the period of obligated service  
18 that would otherwise be required; or

19 “(ii) in the case of contracts entered into  
20 under section 338B, accept a minimum service  
21 obligation of 2 years with an award amount  
22 equal to 50 percent of the amount that would  
23 otherwise be payable for full-time service; and”;  
24 and

1 (C) in paragraph (3), by striking “In evaluating  
2 a demonstration project described in paragraph (1)”  
3 and inserting “In evaluating waivers issued under  
4 paragraph (1)”.

5 (2) Subsection (j) of section 331 of the Public Health  
6 Service Act (42 U.S.C. 254d) is amended by adding at  
7 the end the following:

8 “(5) The terms ‘full time’ and ‘full-time’ mean  
9 a minimum of 40 hours per week in a clinical prac-  
10 tice, for a minimum of 45 weeks per year.

11 “(6) The terms ‘half time’ and ‘half-time’ mean  
12 a minimum of 20 hours per week (not to exceed 39  
13 hours per week) in a clinical practice, for a min-  
14 imum of 45 weeks per year.”.

15 (3) Section 337(b)(1) of the Public Health Service  
16 Act (42 U.S.C. 254j(b)(1)) is amended by striking “Mem-  
17 bers may not be reappointed to the Council.”.

18 (4) Section 338B(g)(2)(A) of the Public Health Serv-  
19 ice Act (42 U.S.C. 254l-1(g)(2)(A)) is amended by strik-  
20 ing “\$35,000” and inserting “\$50,000, plus, beginning  
21 with fiscal year 2012, an amount determined by the Sec-  
22 retary on an annual basis to reflect inflation,”.

23 (5) Subsection (a) of section 338C of the Public  
24 Health Service Act (42 U.S.C. 254m), as amended by sec-  
25 tion 5508, is amended—

1 (A) by striking the second sentence and insert-  
2 ing the following: “The Secretary may treat teaching  
3 as clinical practice for up to 20 percent of such pe-  
4 riod of obligated service.”; and

5 (B) by adding at the end the following: “Not-  
6 withstanding the preceding sentence, with respect to  
7 a member of the Corps participating in the teaching  
8 health centers graduate medical education program  
9 under section 340H, for the purpose of calculating  
10 time spent in full-time clinical practice under this  
11 section, up to 50 percent of time spent teaching by  
12 such member may be counted toward his or her  
13 service obligation.”.

14 **SEC. 10502. INFRASTRUCTURE TO EXPAND ACCESS TO**  
15 **CARE.**

16 (a) APPROPRIATION.—There are authorized to be ap-  
17 propriated, and there are appropriated to the Department  
18 of Health and Human Services, \$100,000,000 for fiscal  
19 year 2010, to remain available for obligation until Sep-  
20 tember 30, 2011, to be used for debt service on, or direct  
21 construction or renovation of, a health care facility that  
22 provides research, inpatient tertiary care, or outpatient  
23 clinical services. Such facility shall be affiliated with an  
24 academic health center at a public research university in

1 the United States that contains a State's sole public aca-  
2 demic medical and dental school.

3 (b) REQUIREMENT.—Amount appropriated under  
4 subsection (a) may only be made available by the Sec-  
5 retary of Health and Human Services upon the receipt of  
6 an application from the Governor of a State that certifies  
7 that—

8 (1) the new health care facility is critical for  
9 the provision of greater access to health care within  
10 the State;

11 (2) such facility is essential for the continued  
12 financial viability of the State's sole public medical  
13 and dental school and its academic health center;

14 (3) the request for Federal support represents  
15 not more than 40 percent of the total cost of the  
16 proposed new facility; and

17 (4) the State has established a dedicated fund-  
18 ing mechanism to provide all remaining funds nec-  
19 essary to complete the construction or renovation of  
20 the proposed facility.

21 **SEC. 10503. COMMUNITY HEALTH CENTERS AND THE NA-**  
22 **TIONAL HEALTH SERVICE CORPS FUND.**

23 (a) PURPOSE.—It is the purpose of this section to  
24 establish a Community Health Center Fund (referred to  
25 in this section as the “CHC Fund”), to be administered

## 330

1 through the Office of the Secretary of the Department of  
2 Health and Human Services to provide for expanded and  
3 sustained national investment in community health cen-  
4 ters under section 330 of the Public Health Service Act  
5 and the National Health Service Corps.

6 (b) FUNDING.—There is authorized to be appro-  
7 priated, and there is appropriated, out of any monies in  
8 the Treasury not otherwise appropriated, to the CHC  
9 Fund—

10 (1) to be transferred to the Secretary of Health  
11 and Human Services to provide enhanced funding  
12 for the community health center program under sec-  
13 tion 330 of the Public Health Service Act—

14 (A) \$700,000,000 for fiscal year 2011;

15 (B) \$800,000,000 for fiscal year 2012;

16 (C) \$1,000,000,000 for fiscal year 2013;

17 (D) \$1,600,000,000 for fiscal year 2014;

18 and

19 (E) \$2,900,000,000 for fiscal year 2015;

20 and

21 (2) to be transferred to the Secretary of Health  
22 and Human Services to provide enhanced funding  
23 for the National Health Service Corps—

24 (A) \$290,000,000 for fiscal year 2011;

25 (B) \$295,000,000 for fiscal year 2012;

1 (C) \$300,000,000 for fiscal year 2013;

2 (D) \$305,000,000 for fiscal year 2014;

3 and

4 (E) \$310,000,000 for fiscal year 2015.

5 (c) CONSTRUCTION.—There is authorized to be ap-  
6 propriated, and there is appropriated, out of any monies  
7 in the Treasury not otherwise appropriated,  
8 \$1,500,000,000 to be available for fiscal years 2011  
9 through 2015 to be used by the Secretary of Health and  
10 Human Services for the construction and renovation of  
11 community health centers.

12 (d) USE OF FUND.—The Secretary of Health and  
13 Human Services shall transfer amounts in the CHC Fund  
14 to accounts within the Department of Health and Human  
15 Services to increase funding, over the fiscal year 2008  
16 level, for community health centers and the National  
17 Health Service Corps.

18 (e) AVAILABILITY.—Amounts appropriated under  
19 subsections (b) and (c) shall remain available until ex-  
20 pended.

21 **SEC. 10504. DEMONSTRATION PROJECT TO PROVIDE AC-**  
22 **CESS TO AFFORDABLE CARE.**

23 (a) IN GENERAL.—Not later than 6 months after the  
24 date of enactment of this Act, the Secretary of Health and  
25 Human Services (referred to in this section as the “Sec-

1 retary”), acting through the Health Resources and Serv-  
2 ices Administration, shall establish a 3 year demonstration  
3 project in up to 10 States to provide access to comprehen-  
4 sive health care services to the uninsured at reduced fees.  
5 The Secretary shall evaluate the feasibility of expanding  
6 the project to additional States.

7 (b) ELIGIBILITY.—To be eligible to participate in the  
8 demonstration project, an entity shall be a State-based,  
9 nonprofit, public-private partnership that provides access  
10 to comprehensive health care services to the uninsured at  
11 reduced fees. Each State in which a participant selected  
12 by the Secretary is located shall receive not more than  
13 \$2,000,000 to establish and carry out the project for the  
14 3-year demonstration period.

15 (c) AUTHORIZATION.—There is authorized to be ap-  
16 propriated such sums as may be necessary to carry out  
17 this section.

## 18 **Subtitle F—Provisions Relating to** 19 **Title VI**

### 20 **SEC. 10601. REVISIONS TO LIMITATION ON MEDICARE EX-** 21 **CEPTION TO THE PROHIBITION ON CERTAIN** 22 **PHYSICIAN REFERRALS FOR HOSPITALS.**

23 (a) IN GENERAL.—Section 1877(i) of the Social Se-  
24 curity Act, as added by section 6001(a), is amended—

1 (1) in paragraph (1)(A)(i), by striking “Feb-  
2 ruary 1, 2010” and inserting “August 1, 2010”; and

3 (2) in paragraph (3)(A)—

4 (A) in clause (iii), by striking “August 1,  
5 2011” and inserting “February 1, 2012”; and

6 (B) in clause (iv), by striking “July 1,  
7 2011” and inserting “January 1, 2012”.

8 (b) CONFORMING AMENDMENT.—Section 6001(b)(2)  
9 of this Act is amended by striking “November 1, 2011”  
10 and inserting “May 1, 2012”.

11 **SEC. 10602. CLARIFICATIONS TO PATIENT-CENTERED OUT-**  
12 **COMES RESEARCH.**

13 Section 1181 of the Social Security Act (as added by  
14 section 6301) is amended—

15 (1) in subsection (d)(2)(B)—

16 (A) in clause (ii)(IV)—

17 (i) by inserting “, as described in sub-  
18 paragraph (A)(ii),” after “original re-  
19 search”; and

20 (ii) by inserting “, as long as the re-  
21 searcher enters into a data use agreement  
22 with the Institute for use of the data from  
23 the original research, as appropriate” after  
24 “publication”; and

1 (B) by amending clause (iv) to read as fol-  
2 lows:

3 “(iv) SUBSEQUENT USE OF THE  
4 DATA.—The Institute shall not allow the  
5 subsequent use of data from original re-  
6 search in work-for-hire contracts with indi-  
7 viduals, entities, or instrumentalities that  
8 have a financial interest in the results, un-  
9 less approved under a data use agreement  
10 with the Institute.”;

11 (2) in subsection (d)(8)(A)(iv), by striking “not  
12 be construed as mandates for” and inserting “do not  
13 include”; and

14 (3) in subsection (f)(1)(C), by amending clause  
15 (ii) to read as follows:

16 “(ii) 7 members representing physi-  
17 cians and providers, including 4 members  
18 representing physicians (at least 1 of  
19 whom is a surgeon), 1 nurse, 1 State-li-  
20 censed integrative health care practitioner,  
21 and 1 representative of a hospital.”.

1 **SEC. 10603. STRIKING PROVISIONS RELATING TO INDI-**  
2 **VIDUAL PROVIDER APPLICATION FEES.**

3 (a) IN GENERAL.—Section 1866(j)(2)(C) of the So-  
4 cial Security Act, as added by section 6401(a), is amend-  
5 ed—

6 (1) by striking clause (i);

7 (2) by redesignating clauses (ii) through (iv),  
8 respectively, as clauses (i) through (iii); and

9 (3) in clause (i), as redesignated by paragraph  
10 (2), by striking “clause (iii)” and inserting “clause  
11 (ii)”.

12 (b) TECHNICAL CORRECTION.—Section 6401(a)(2)  
13 of this Act is amended to read as follows:

14 “(2) by redesignating paragraph (2) as para-  
15 graph (8); and”.

16 **SEC. 10604. TECHNICAL CORRECTION TO SECTION 6405.**

17 Paragraphs (1) and (2) of section 6405(b) are  
18 amended to read as follows:

19 “(1) PART A.—Section 1814(a)(2) of the Social  
20 Security Act (42 U.S.C. 1395(a)(2)) is amended in  
21 the matter preceding subparagraph (A) by inserting  
22 ‘, or, in the case of services described in subpara-  
23 graph (C), a physician enrolled under section  
24 1866(j),’ after ‘in collaboration with a physician,’.

25 “(2) PART B.—Section 1835(a)(2) of the Social  
26 Security Act (42 U.S.C. 1395n(a)(2)) is amended in

1 the matter preceding subparagraph (A) by inserting  
2 ‘, or, in the case of services described in subpara-  
3 graph (A), a physician enrolled under section  
4 1866(j),’ after ‘a physician’.”.

5 **SEC. 10605. CERTAIN OTHER PROVIDERS PERMITTED TO**  
6 **CONDUCT FACE TO FACE ENCOUNTER FOR**  
7 **HOME HEALTH SERVICES.**

8 (a) PART A.—Section 1814(a)(2)(C) of the Social Se-  
9 curity Act (42 U.S.C. 1395f(a)(2)(C)), as amended by sec-  
10 tion 6407(a)(1), is amended by inserting “, or a nurse  
11 practitioner or clinical nurse specialist (as those terms are  
12 defined in section 1861(aa)(5)) who is working in collabo-  
13 ration with the physician in accordance with State law,  
14 or a certified nurse-midwife (as defined in section  
15 1861(gg)) as authorized by State law, or a physician as-  
16 sistant (as defined in section 1861(aa)(5)) under the su-  
17 pervision of the physician,” after “himself or herself”.

18 (b) PART B.—Section 1835(a)(2)(A)(iv) of the Social  
19 Security Act, as added by section 6407(a)(2), is amended  
20 by inserting “, or a nurse practitioner or clinical nurse  
21 specialist (as those terms are defined in section  
22 1861(aa)(5)) who is working in collaboration with the phy-  
23 sician in accordance with State law, or a certified nurse-  
24 midwife (as defined in section 1861(gg)) as authorized by  
25 State law, or a physician assistant (as defined in section

1 1861(aa)(5)) under the supervision of the physician,”  
2 after “must document that the physician”.

3 **SEC. 10606. HEALTH CARE FRAUD ENFORCEMENT.**

4 (a) FRAUD SENTENCING GUIDELINES.—

5 (1) DEFINITION.—In this subsection, the term  
6 “Federal health care offense” has the meaning given  
7 that term in section 24 of title 18, United States  
8 Code, as amended by this Act.

9 (2) REVIEW AND AMENDMENTS.—Pursuant to  
10 the authority under section 994 of title 28, United  
11 States Code, and in accordance with this subsection,  
12 the United States Sentencing Commission shall—

13 (A) review the Federal Sentencing Guide-  
14 lines and policy statements applicable to per-  
15 sons convicted of Federal health care offenses;

16 (B) amend the Federal Sentencing Guide-  
17 lines and policy statements applicable to per-  
18 sons convicted of Federal health care offenses  
19 involving Government health care programs to  
20 provide that the aggregate dollar amount of  
21 fraudulent bills submitted to the Government  
22 health care program shall constitute prima facie  
23 evidence of the amount of the intended loss by  
24 the defendant; and

1 (C) amend the Federal Sentencing Guide-  
2 lines to provide—

3 (i) a 2-level increase in the offense  
4 level for any defendant convicted of a Fed-  
5 eral health care offense relating to a Gov-  
6 ernment health care program which in-  
7 volves a loss of not less than \$1,000,000  
8 and less than \$7,000,000;

9 (ii) a 3-level increase in the offense  
10 level for any defendant convicted of a Fed-  
11 eral health care offense relating to a Gov-  
12 ernment health care program which in-  
13 volves a loss of not less than \$7,000,000  
14 and less than \$20,000,000;

15 (iii) a 4-level increase in the offense  
16 level for any defendant convicted of a Fed-  
17 eral health care offense relating to a Gov-  
18 ernment health care program which in-  
19 volves a loss of not less than \$20,000,000;  
20 and

21 (iv) if appropriate, otherwise amend  
22 the Federal Sentencing Guidelines and pol-  
23 icy statements applicable to persons con-  
24 victed of Federal health care offenses in-  
25 volving Government health care programs.

1           (3) REQUIREMENTS.—In carrying this sub-  
2           section, the United States Sentencing Commission  
3           shall—

4                   (A) ensure that the Federal Sentencing  
5           Guidelines and policy statements—

6                           (i) reflect the serious harms associ-  
7                           ated with health care fraud and the need  
8                           for aggressive and appropriate law enforce-  
9                           ment action to prevent such fraud; and

10                           (ii) provide increased penalties for  
11                           persons convicted of health care fraud of-  
12                           fenses in appropriate circumstances;

13                   (B) consult with individuals or groups rep-  
14           resenting health care fraud victims, law enforce-  
15           ment officials, the health care industry, and the  
16           Federal judiciary as part of the review de-  
17           scribed in paragraph (2);

18                   (C) ensure reasonable consistency with  
19           other relevant directives and with other guide-  
20           lines under the Federal Sentencing Guidelines;

21                   (D) account for any aggravating or miti-  
22           gating circumstances that might justify excep-  
23           tions, including circumstances for which the  
24           Federal Sentencing Guidelines, as in effect on

1 the date of enactment of this Act, provide sen-  
2 tencing enhancements;

3 (E) make any necessary conforming  
4 changes to the Federal Sentencing Guidelines;  
5 and

6 (F) ensure that the Federal Sentencing  
7 Guidelines adequately meet the purposes of sen-  
8 tencing.

9 (b) INTENT REQUIREMENT FOR HEALTH CARE  
10 FRAUD.—Section 1347 of title 18, United States Code,  
11 is amended—

12 (1) by inserting “(a)” before “Whoever know-  
13 ingly”; and

14 (2) by adding at the end the following:

15 “(b) With respect to violations of this section, a per-  
16 son need not have actual knowledge of this section or spe-  
17 cific intent to commit a violation of this section.”.

18 (c) HEALTH CARE FRAUD OFFENSE.—Section 24(a)  
19 of title 18, United States Code, is amended—

20 (1) in paragraph (1), by striking the semicolon  
21 and inserting “or section 1128B of the Social Secu-  
22 rity Act (42 U.S.C. 1320a–7b); or”; and

23 (2) in paragraph (2)—

24 (A) by inserting “1349,” after “1343,”;  
25 and

1 (B) by inserting “section 301 of the Fed-  
2 eral Food, Drug, and Cosmetic Act (21 U.S.C.  
3 331), or section 501 of the Employee Retire-  
4 ment Income Security Act of 1974 (29 U.S.C.  
5 1131),” after “title,”.

6 (d) SUBPOENA AUTHORITY RELATING TO HEALTH  
7 CARE.—

8 (1) SUBPOENAS UNDER THE HEALTH INSUR-  
9 ANCE PORTABILITY AND ACCOUNTABILITY ACT OF  
10 1996.—Section 1510(b) of title 18, United States  
11 Code, is amended—

12 (A) in paragraph (1), by striking “to the  
13 grand jury”; and

14 (B) in paragraph (2)—

15 (i) in subparagraph (A), by striking  
16 “grand jury subpoena” and inserting “sub-  
17 poena for records”; and

18 (ii) in the matter following subpara-  
19 graph (B), by striking “to the grand jury”.

20 (2) SUBPOENAS UNDER THE CIVIL RIGHTS OF  
21 INSTITUTIONALIZED PERSONS ACT.—The Civil  
22 Rights of Institutionalized Persons Act (42 U.S.C.  
23 1997 et seq.) is amended by inserting after section  
24 3 the following:

1 **“SEC. 3A. SUBPOENA AUTHORITY.**

2       “(a) **AUTHORITY.**—The Attorney General, or at the  
3 direction of the Attorney General, any officer or employee  
4 of the Department of Justice may require by subpoena  
5 access to any institution that is the subject of an investiga-  
6 tion under this Act and to any document, record, material,  
7 file, report, memorandum, policy, procedure, investigation,  
8 video or audio recording, or quality assurance report relat-  
9 ing to any institution that is the subject of an investiga-  
10 tion under this Act to determine whether there are condi-  
11 tions which deprive persons residing in or confined to the  
12 institution of any rights, privileges, or immunities secured  
13 or protected by the Constitution or laws of the United  
14 States.

15       “(b) **ISSUANCE AND ENFORCEMENT OF SUB-**  
16 **POENAS.**—

17               “(1) **ISSUANCE.**—Subpoenas issued under this  
18 section—

19                       “(A) shall bear the signature of the Attor-  
20 ney General or any officer or employee of the  
21 Department of Justice as designated by the At-  
22 torney General; and

23                       “(B) shall be served by any person or class  
24 of persons designated by the Attorney General  
25 or a designated officer or employee for that  
26 purpose.

1           “(2) ENFORCEMENT.—In the case of contu-  
2           macy or failure to obey a subpoena issued under this  
3           section, the United States district court for the judi-  
4           cial district in which the institution is located may  
5           issue an order requiring compliance. Any failure to  
6           obey the order of the court may be punished by the  
7           court as a contempt that court.

8           “(c) PROTECTION OF SUBPOENAED RECORDS AND  
9           INFORMATION.—Any document, record, material, file, re-  
10          port, memorandum, policy, procedure, investigation, video  
11          or audio recording, or quality assurance report or other  
12          information obtained under a subpoena issued under this  
13          section—

14                 “(1) may not be used for any purpose other  
15                 than to protect the rights, privileges, or immunities  
16                 secured or protected by the Constitution or laws of  
17                 the United States of persons who reside, have re-  
18                 sided, or will reside in an institution;

19                 “(2) may not be transmitted by or within the  
20                 Department of Justice for any purpose other than to  
21                 protect the rights, privileges, or immunities secured  
22                 or protected by the Constitution or laws of the  
23                 United States of persons who reside, have resided,  
24                 or will reside in an institution; and

1           “(3) shall be redacted, obscured, or otherwise  
2           altered if used in any publicly available manner so  
3           as to prevent the disclosure of any personally identi-  
4           fiable information.”.

5 **SEC. 10607. STATE DEMONSTRATION PROGRAMS TO EVALU-**  
6                           **ATE ALTERNATIVES TO CURRENT MEDICAL**  
7                           **TORT LITIGATION.**

8           Part P of title III of the Public Health Service Act  
9           (42 U.S.C. 280g et seq.), as amended by this Act, is fur-  
10          ther amended by adding at the end the following:

11 **“SEC. 399V-4. STATE DEMONSTRATION PROGRAMS TO**  
12                           **EVALUATE ALTERNATIVES TO CURRENT**  
13                           **MEDICAL TORT LITIGATION.**

14          “(a) IN GENERAL.—The Secretary is authorized to  
15          award demonstration grants to States for the develop-  
16          ment, implementation, and evaluation of alternatives to  
17          current tort litigation for resolving disputes over injuries  
18          allegedly caused by health care providers or health care  
19          organizations. In awarding such grants, the Secretary  
20          shall ensure the diversity of the alternatives so funded.

21          “(b) DURATION.—The Secretary may award grants  
22          under subsection (a) for a period not to exceed 5 years.

23          “(c) CONDITIONS FOR DEMONSTRATION GRANTS.—

1           “(1) REQUIREMENTS.—Each State desiring a  
2 grant under subsection (a) shall develop an alter-  
3 native to current tort litigation that—

4           “(A) allows for the resolution of disputes  
5 over injuries allegedly caused by health care  
6 providers or health care organizations; and

7           “(B) promotes a reduction of health care  
8 errors by encouraging the collection and anal-  
9 ysis of patient safety data related to disputes  
10 resolved under subparagraph (A) by organiza-  
11 tions that engage in efforts to improve patient  
12 safety and the quality of health care.

13           “(2) ALTERNATIVE TO CURRENT TORT LITIGA-  
14 TION.—Each State desiring a grant under sub-  
15 section (a) shall demonstrate how the proposed al-  
16 ternative described in paragraph (1)(A)—

17           “(A) makes the medical liability system  
18 more reliable by increasing the availability of  
19 prompt and fair resolution of disputes;

20           “(B) encourages the efficient resolution of  
21 disputes;

22           “(C) encourages the disclosure of health  
23 care errors;

1           “(D) enhances patient safety by detecting,  
2 analyzing, and helping to reduce medical errors  
3 and adverse events;

4           “(E) improves access to liability insurance;

5           “(F) fully informs patients about the dif-  
6 ferences in the alternative and current tort liti-  
7 gation;

8           “(G) provides patients the ability to opt  
9 out of or voluntarily withdraw from partici-  
10 pating in the alternative at any time and to  
11 pursue other options, including litigation, out-  
12 side the alternative;

13           “(H) would not conflict with State law at  
14 the time of the application in a way that would  
15 prohibit the adoption of an alternative to cur-  
16 rent tort litigation; and

17           “(I) would not limit or curtail a patient’s  
18 existing legal rights, ability to file a claim in or  
19 access a State’s legal system, or otherwise abro-  
20 gate a patient’s ability to file a medical mal-  
21 practice claim.

22           “(3) SOURCES OF COMPENSATION.—Each State  
23 desiring a grant under subsection (a) shall identify  
24 the sources from and methods by which compensa-  
25 tion would be paid for claims resolved under the pro-

1 posed alternative to current tort litigation, which  
2 may include public or private funding sources, or a  
3 combination of such sources. Funding methods shall  
4 to the extent practicable provide financial incentives  
5 for activities that improve patient safety.

6 “(4) SCOPE.—

7 “(A) IN GENERAL.—Each State desiring a  
8 grant under subsection (a) shall establish a  
9 scope of jurisdiction (such as Statewide, des-  
10 ignated geographic region, a designated area of  
11 health care practice, or a designated group of  
12 health care providers or health care organiza-  
13 tions) for the proposed alternative to current  
14 tort litigation that is sufficient to evaluate the  
15 effects of the alternative. No scope of jurisdic-  
16 tion shall be established under this paragraph  
17 that is based on a health care payer or patient  
18 population.

19 “(B) NOTIFICATION OF PATIENTS.—A  
20 State shall demonstrate how patients would be  
21 notified that they are receiving health care serv-  
22 ices that fall within such scope, and the process  
23 by which they may opt out of or voluntarily  
24 withdraw from participating in the alternative.  
25 The decision of the patient whether to partici-

1           pate or continue participating in the alternative  
2           process shall be made at any time and shall not  
3           be limited in any way.

4           “(5) PREFERENCE IN AWARDING DEMONSTRATION  
5           GRANTS.—In awarding grants under sub-  
6           section (a), the Secretary shall give preference to  
7           States—

8                   “(A) that have developed the proposed al-  
9                   ternative through substantive consultation with  
10                  relevant stakeholders, including patient advo-  
11                  cates, health care providers and health care or-  
12                  ganizations, attorneys with expertise in rep-  
13                  resenting patients and health care providers,  
14                  medical malpractice insurers, and patient safety  
15                  experts;

16                   “(B) that make proposals that are likely to  
17                  enhance patient safety by detecting, analyzing,  
18                  and helping to reduce medical errors and ad-  
19                  verse events; and

20                   “(C) that make proposals that are likely to  
21                  improve access to liability insurance.

22           “(d) APPLICATION.—

23                   “(1) IN GENERAL.—Each State desiring a  
24                  grant under subsection (a) shall submit to the Sec-  
25                  retary an application, at such time, in such manner,

1 and containing such information as the Secretary  
2 may require.

3 “(2) REVIEW PANEL.—

4 “(A) IN GENERAL.—In reviewing applica-  
5 tions under paragraph (1), the Secretary shall  
6 consult with a review panel composed of rel-  
7 evant experts appointed by the Comptroller  
8 General.

9 “(B) COMPOSITION.—

10 “(i) NOMINATIONS.—The Comptroller  
11 General shall solicit nominations from the  
12 public for individuals to serve on the re-  
13 view panel.

14 “(ii) APPOINTMENT.—The Comp-  
15 troller General shall appoint, at least 9 but  
16 not more than 13, highly qualified and  
17 knowledgeable individuals to serve on the  
18 review panel and shall ensure that the fol-  
19 lowing entities receive fair representation  
20 on such panel:

21 “(I) Patient advocates.

22 “(II) Health care providers and  
23 health care organizations.

1                   “(III) Attorneys with expertise in  
2                   representing patients and health care  
3                   providers.

4                   “(IV) Medical malpractice insur-  
5                   ers.

6                   “(V) State officials.

7                   “(VI) Patient safety experts.

8                   “(C) CHAIRPERSON.—The Comptroller  
9                   General, or an individual within the Govern-  
10                  ment Accountability Office designated by the  
11                  Comptroller General, shall be the chairperson of  
12                  the review panel.

13                  “(D) AVAILABILITY OF INFORMATION.—  
14                  The Comptroller General shall make available  
15                  to the review panel such information, personnel,  
16                  and administrative services and assistance as  
17                  the review panel may reasonably require to  
18                  carry out its duties.

19                  “(E) INFORMATION FROM AGENCIES.—The  
20                  review panel may request directly from any de-  
21                  partment or agency of the United States any  
22                  information that such panel considers necessary  
23                  to carry out its duties. To the extent consistent  
24                  with applicable laws and regulations, the head

1           of such department or agency shall furnish the  
2           requested information to the review panel.

3           “(e) REPORTS.—

4           “(1) BY STATE.—Each State receiving a grant  
5           under subsection (a) shall submit to the Secretary  
6           an annual report evaluating the effectiveness of ac-  
7           tivities funded with grants awarded under such sub-  
8           section. Such report shall, at a minimum, include  
9           the impact of the activities funded on patient safety  
10          and on the availability and price of medical liability  
11          insurance.

12          “(2) BY SECRETARY.—The Secretary shall sub-  
13          mit to Congress an annual compendium of the re-  
14          ports submitted under paragraph (1) and an anal-  
15          ysis of the activities funded under subsection (a)  
16          that examines any differences that result from such  
17          activities in terms of the quality of care, number and  
18          nature of medical errors, medical resources used,  
19          length of time for dispute resolution, and the avail-  
20          ability and price of liability insurance.

21          “(f) TECHNICAL ASSISTANCE.—

22          “(1) IN GENERAL.—The Secretary shall provide  
23          technical assistance to the States applying for or  
24          awarded grants under subsection (a).

1           “(2) REQUIREMENTS.—Technical assistance  
2 under paragraph (1) shall include—

3           “(A) guidance on non-economic damages,  
4 including the consideration of individual facts  
5 and circumstances in determining appropriate  
6 payment, guidance on identifying avoidable in-  
7 juries, and guidance on disclosure to patients of  
8 health care errors and adverse events; and

9           “(B) the development, in consultation with  
10 States, of common definitions, formats, and  
11 data collection infrastructure for States receiv-  
12 ing grants under this section to use in reporting  
13 to facilitate aggregation and analysis of data  
14 both within and between States.

15           “(3) USE OF COMMON DEFINITIONS, FORMATS,  
16 AND DATA COLLECTION INFRASTRUCTURE.—States  
17 not receiving grants under this section may also use  
18 the common definitions, formats, and data collection  
19 infrastructure developed under paragraph (2)(B).

20           “(g) EVALUATION.—

21           “(1) IN GENERAL.—The Secretary, in consulta-  
22 tion with the review panel established under sub-  
23 section (d)(2), shall enter into a contract with an ap-  
24 propriate research organization to conduct an overall  
25 evaluation of the effectiveness of grants awarded

1 under subsection (a) and to annually prepare and  
2 submit a report to Congress. Such an evaluation  
3 shall begin not later than 18 months following the  
4 date of implementation of the first program funded  
5 by a grant under subsection (a).

6 “(2) CONTENTS.—The evaluation under para-  
7 graph (1) shall include—

8 “(A) an analysis of the effects of the  
9 grants awarded under subsection (a) with re-  
10 gard to the measures described in paragraph  
11 (3);

12 “(B) for each State, an analysis of the ex-  
13 tent to which the alternative developed under  
14 subsection (c)(1) is effective in meeting the ele-  
15 ments described in subsection (c)(2);

16 “(C) a comparison among the States re-  
17 ceiving grants under subsection (a) of the effec-  
18 tiveness of the various alternatives developed by  
19 such States under subsection (c)(1);

20 “(D) a comparison, considering the meas-  
21 ures described in paragraph (3), of States re-  
22 ceiving grants approved under subsection (a)  
23 and similar States not receiving such grants;  
24 and

1           “(E) a comparison, with regard to the  
2 measures described in paragraph (3), of—

3           “(i) States receiving grants under  
4 subsection (a);

5           “(ii) States that enacted, prior to the  
6 date of enactment of the Patient Protec-  
7 tion and Affordable Care Act, any cap on  
8 non-economic damages; and

9           “(iii) States that have enacted, prior  
10 to the date of enactment of the Patient  
11 Protection and Affordable Care Act, a re-  
12 quirement that the complainant obtain an  
13 opinion regarding the merit of the claim,  
14 although the substance of such opinion  
15 may have no bearing on whether the com-  
16 plainant may proceed with a case.

17           “(3) MEASURES.—The evaluations under para-  
18 graph (2) shall analyze and make comparisons on  
19 the basis of—

20           “(A) the nature and number of disputes  
21 over injuries allegedly caused by health care  
22 providers or health care organizations;

23           “(B) the nature and number of claims in  
24 which tort litigation was pursued despite the ex-  
25 istence of an alternative under subsection (a);

1           “(C) the disposition of disputes and claims,  
2 including the length of time and estimated costs  
3 to all parties;

4           “(D) the medical liability environment;

5           “(E) health care quality;

6           “(F) patient safety in terms of detecting,  
7 analyzing, and helping to reduce medical errors  
8 and adverse events;

9           “(G) patient and health care provider and  
10 organization satisfaction with the alternative  
11 under subsection (a) and with the medical li-  
12 ability environment; and

13           “(H) impact on utilization of medical serv-  
14 ices, appropriately adjusted for risk.

15           “(4) FUNDING.—The Secretary shall reserve 5  
16 percent of the amount appropriated in each fiscal  
17 year under subsection (k) to carry out this sub-  
18 section.

19           “(h) MEDPAC AND MACPAC REPORTS.—

20           “(1) MEDPAC.—The Medicare Payment Advi-  
21 sory Commission shall conduct an independent re-  
22 view of the alternatives to current tort litigation that  
23 are implemented under grants under subsection (a)  
24 to determine the impact of such alternatives on the

1 Medicare program under title XVIII of the Social  
2 Security Act, and its beneficiaries.

3 “(2) MACPAC.—The Medicaid and CHIP Pay-  
4 ment and Access Commission shall conduct an inde-  
5 pendent review of the alternatives to current tort  
6 litigation that are implemented under grants under  
7 subsection (a) to determine the impact of such alter-  
8 natives on the Medicaid or CHIP programs under ti-  
9 tles XIX and XXI of the Social Security Act, and  
10 their beneficiaries.

11 “(3) REPORTS.—Not later than December 31,  
12 2016, the Medicare Payment Advisory Commission  
13 and the Medicaid and CHIP Payment and Access  
14 Commission shall each submit to Congress a report  
15 that includes the findings and recommendations of  
16 each respective Commission based on independent  
17 reviews conducted under paragraphs (1) and (2), in-  
18 cluding an analysis of the impact of the alternatives  
19 reviewed on the efficiency and effectiveness of the  
20 respective programs.

21 “(i) OPTION TO PROVIDE FOR INITIAL PLANNING  
22 GRANTS.—Of the funds appropriated pursuant to sub-  
23 section (k), the Secretary may use a portion not to exceed  
24 \$500,000 per State to provide planning grants to such  
25 States for the development of demonstration project appli-

1 cations meeting the criteria described in subsection (c).  
2 In selecting States to receive such planning grants, the  
3 Secretary shall give preference to those States in which  
4 State law at the time of the application would not prohibit  
5 the adoption of an alternative to current tort litigation.

6 “(j) DEFINITIONS.—In this section:

7 “(1) HEALTH CARE SERVICES.—The term  
8 ‘health care services’ means any services provided by  
9 a health care provider, or by any individual working  
10 under the supervision of a health care provider, that  
11 relate to—

12 “(A) the diagnosis, prevention, or treat-  
13 ment of any human disease or impairment; or

14 “(B) the assessment of the health of  
15 human beings.

16 “(2) HEALTH CARE ORGANIZATION.—The term  
17 ‘health care organization’ means any individual or  
18 entity which is obligated to provide, pay for, or ad-  
19 minister health benefits under any health plan.

20 “(3) HEALTH CARE PROVIDER.—The term  
21 ‘health care provider’ means any individual or enti-  
22 ty—

23 “(A) licensed, registered, or certified under  
24 Federal or State laws or regulations to provide  
25 health care services; or

1           “(B) required to be so licensed, registered,  
2           or certified but that is exempted by other stat-  
3           ute or regulation.

4           “(k) AUTHORIZATION OF APPROPRIATIONS.—There  
5 are authorized to be appropriated to carry out this section,  
6 \$50,000,000 for the 5-fiscal year period beginning with  
7 fiscal year 2011.

8           “(l) CURRENT STATE EFFORTS TO ESTABLISH AL-  
9           TERNATIVE TO TORT LITIGATION.—Nothing in this sec-  
10 tion shall be construed to limit any prior, current, or fu-  
11 ture efforts of any State to establish any alternative to  
12 tort litigation.

13           “(m) RULE OF CONSTRUCTION.—Nothing in this sec-  
14 tion shall be construed as limiting states’ authority over  
15 or responsibility for their state justice systems.”.

16 **SEC. 10608. EXTENSION OF MEDICAL MALPRACTICE COV-**  
17 **ERAGE TO FREE CLINICS.**

18           (a) IN GENERAL.—Section 224(o)(1) of the Public  
19 Health Service Act (42 U.S.C. 233(o)(1)) is amended by  
20 inserting after “to an individual” the following: “, or an  
21 officer, governing board member, employee, or contractor  
22 of a free clinic shall in providing services for the free clin-  
23 ic,”.

24           (b) EFFECTIVE DATE.—The amendment made by  
25 this section shall take effect on the date of enactment of

1 this Act and apply to any act or omission which occurs  
2 on or after that date.

3 **SEC. 10609. LABELING CHANGES.**

4 Section 505(j) of the Federal Food, Drug, and Cos-  
5 metic Act (21 U.S.C. 355(j)) is amended by adding at the  
6 end the following:

7 “(10)(A) If the proposed labeling of a drug that is  
8 the subject of an application under this subsection differs  
9 from the listed drug due to a labeling revision described  
10 under clause (i), the drug that is the subject of such appli-  
11 cation shall, notwithstanding any other provision of this  
12 Act, be eligible for approval and shall not be considered  
13 misbranded under section 502 if—

14 “(i) the application is otherwise eligible for ap-  
15 proval under this subsection but for expiration of  
16 patent, an exclusivity period, or of a delay in ap-  
17 proval described in paragraph (5)(B)(iii), and a revi-  
18 sion to the labeling of the listed drug has been ap-  
19 proved by the Secretary within 60 days of such expi-  
20 ration;

21 “(ii) the labeling revision described under clause  
22 (i) does not include a change to the ‘Warnings’ sec-  
23 tion of the labeling;

24 “(iii) the sponsor of the application under this  
25 subsection agrees to submit revised labeling of the

1 drug that is the subject of such application not later  
2 than 60 days after the notification of any changes  
3 to such labeling required by the Secretary; and

4 “(iv) such application otherwise meets the ap-  
5 plicable requirements for approval under this sub-  
6 section.

7 “(B) If, after a labeling revision described in sub-  
8 paragraph (A)(i), the Secretary determines that the con-  
9 tinued presence in interstate commerce of the labeling of  
10 the listed drug (as in effect before the revision described  
11 in subparagraph (A)(i)) adversely impacts the safe use of  
12 the drug, no application under this subsection shall be eli-  
13 gible for approval with such labeling.”.

14 **Subtitle G—Provisions Relating to**  
15 **Title VIII**

16 **SEC. 10801. PROVISIONS RELATING TO TITLE VIII.**

17 (a) Title XXXII of the Public Health Service Act,  
18 as added by section 8002(a)(1), is amended—

19 (1) in section 3203—

20 (A) in subsection (a)(1), by striking sub-  
21 paragraph (E);

22 (B) in subsection (b)(1)(C)(i), by striking  
23 “for enrollment” and inserting “for reenroll-  
24 ment”; and

1 (C) in subsection (c)(1), by striking “, as  
2 part of their automatic enrollment in the  
3 CLASS program,”; and

4 (2) in section 3204—

5 (A) in subsection (e)(2), by striking sub-  
6 paragraph (A) and inserting the following:

7 “(A) receives wages or income on which  
8 there is imposed a tax under section 3101(a) or  
9 3201(a) of the Internal Revenue Code of 1986;  
10 or”;

11 (B) in subsection (d), by striking “sub-  
12 paragraph (B) or (C) of subsection (c)(1)” and  
13 inserting “subparagraph (A) or (B) of sub-  
14 section (e)(2)”;

15 (C) in subsection (e)(2)(A), by striking  
16 “subparagraph (A)” and inserting “paragraph  
17 (1)”;

18 (D) in subsection (g)(1), by striking “has  
19 elected to waive enrollment” and inserting “has  
20 not enrolled”.

21 (b) Section 8002 of this Act is amended in the head-  
22 ing for subsection (d), by striking “INFORMATION ON SUP-  
23 PLEMENTAL COVERAGE” and inserting “CLASS PRO-  
24 GRAM INFORMATION”.

1 (c) Section 6021(d)(2)(A)(iv) of the Deficit Reduc-  
2 tion Act of 2005, as added by section 8002(d) of this Act,  
3 is amended by striking “and coverage available” and all  
4 that follows through “that program,”.

5 **Subtitle H—Provisions Relating to**  
6 **Title IX**

7 **SEC. 10901. MODIFICATIONS TO EXCISE TAX ON HIGH COST**  
8 **EMPLOYER-SPONSORED HEALTH COVERAGE.**

9 (a) LONGSHORE WORKERS TREATED AS EMPLOYEES  
10 ENGAGED IN HIGH-RISK PROFESSIONS.—Paragraph (3)  
11 of section 4980I(f) of the Internal Revenue Code of 1986,  
12 as added by section 9001 of this Act, is amended by in-  
13 serting “individuals whose primary work is longshore work  
14 (as defined in section 258(b) of the Immigration and Na-  
15 tionality Act (8 U.S.C. 1288(b)), determined without re-  
16 gard to paragraph (2) thereof),” before “and individuals  
17 engaged in the construction, mining”.

18 (b) EXEMPTION FROM HIGH-COST INSURANCE TAX  
19 INCLUDES CERTAIN ADDITIONAL EXCEPTED BENE-  
20 FITS.—Clause (i) of section 4980I(d)(1)(B) of the Inter-  
21 nal Revenue Code of 1986, as added by section 9001 of  
22 this Act, is amended by striking “section 9832(c)(1)(A)”  
23 and inserting “section 9832(c)(1) (other than subpara-  
24 graph (G) thereof)”.

1 (c) EFFECTIVE DATE.—The amendments made by  
2 this section shall apply to taxable years beginning after  
3 December 31, 2012.

4 **SEC. 10902. INFLATION ADJUSTMENT OF LIMITATION ON**  
5 **HEALTH FLEXIBLE SPENDING ARRANGE-**  
6 **MENTS UNDER CAFETERIA PLANS.**

7 (a) IN GENERAL.—Subsection (i) of section 125 of  
8 the Internal Revenue Code of 1986, as added by section  
9 9005 of this Act, is amended to read as follows:

10 “(i) LIMITATION ON HEALTH FLEXIBLE SPENDING  
11 ARRANGEMENTS.—

12 “(1) IN GENERAL.—For purposes of this sec-  
13 tion, if a benefit is provided under a cafeteria plan  
14 through employer contributions to a health flexible  
15 spending arrangement, such benefit shall not be  
16 treated as a qualified benefit unless the cafeteria  
17 plan provides that an employee may not elect for  
18 any taxable year to have salary reduction contribu-  
19 tions in excess of \$2,500 made to such arrangement.

20 “(2) ADJUSTMENT FOR INFLATION.—In the  
21 case of any taxable year beginning after December  
22 31, 2011, the dollar amount in paragraph (1) shall  
23 be increased by an amount equal to—

24 “(A) such amount, multiplied by



1 (1) by striking “2009” in subsection (a)(1) and  
2 inserting “2010”,

3 (2) by inserting “(\$3,000,000,000 after 2017)”  
4 after “\$2,000,000,000”, and

5 (3) by striking “2008” in subsection (i) and in-  
6 serting “2009”.

7 (b) EFFECTIVE DATE.—The amendments made by  
8 this section shall take effect as if included in the enact-  
9 ment of section 9009.

10 **SEC. 10905. MODIFICATION OF ANNUAL FEE ON HEALTH IN-**  
11 **SURANCE PROVIDERS.**

12 (a) DETERMINATION OF FEE AMOUNT.—Subsection  
13 (b) of section 9010 of this Act is amended to read as fol-  
14 lows:

15 “(b) DETERMINATION OF FEE AMOUNT.—

16 “(1) IN GENERAL.—With respect to each cov-  
17 ered entity, the fee under this section for any cal-  
18 endar year shall be equal to an amount that bears  
19 the same ratio to the applicable amount as—

20 “(A) the covered entity’s net premiums  
21 written with respect to health insurance for any  
22 United States health risk that are taken into  
23 account during the preceding calendar year,  
24 bears to

1           “(B) the aggregate net premiums written  
 2           with respect to such health insurance of all cov-  
 3           ered entities that are taken into account during  
 4           such preceding calendar year.

5           “(2) AMOUNTS TAKEN INTO ACCOUNT.—For  
 6           purposes of paragraph (1), the net premiums written  
 7           with respect to health insurance for any United  
 8           States health risk that are taken into account during  
 9           any calendar year with respect to any covered entity  
 10          shall be determined in accordance with the following  
 11          table:

“With respect to a covered entity’s net premiums writ- ten during the calendar year that are:	The percentage of net premiums written that are taken into account is:
Not more than \$25,000,000 .....	0 percent
More than \$25,000,000 but not more than \$50,000,000.	50 percent
More than \$50,000,000 .....	100 percent.

12           “(3) SECRETARIAL DETERMINATION.—The Sec-  
 13           retary shall calculate the amount of each covered en-  
 14           tity’s fee for any calendar year under paragraph (1).  
 15           In calculating such amount, the Secretary shall de-  
 16           termine such covered entity’s net premiums written  
 17           with respect to any United States health risk on the  
 18           basis of reports submitted by the covered entity  
 19           under subsection (g) and through the use of any  
 20           other source of information available to the Sec-  
 21           retary.”.

1 (b) APPLICABLE AMOUNT.—Subsection (e) of section  
2 9010 of this Act is amended to read as follows:

3 “(e) APPLICABLE AMOUNT.—For purposes of sub-  
4 section (b)(1), the applicable amount shall be determined  
5 in accordance with the following table:

<b>“Calendar year</b>	<b>Applicable amount</b>
2011 .....	\$2,000,000,000
2012 .....	\$4,000,000,000
2013 .....	\$7,000,000,000
2014, 2015 and 2016 .....	\$9,000,000,000
2017 and thereafter .....	\$10,000,000,000.”.

6 (c) EXEMPTION FROM ANNUAL FEE ON HEALTH IN-  
7 SURANCE FOR CERTAIN NONPROFIT ENTITIES.—Section  
8 9010(c)(2) of this Act is amended by striking “or” at the  
9 end of subparagraph (A), by striking the period at the  
10 end of subparagraph (B) and inserting a comma, and by  
11 adding at the end the following new subparagraphs:

12 “(C) any entity—

13 “(i)(I) which is incorporated as, is a  
14 wholly owned subsidiary of, or is a wholly  
15 owned affiliate of, a nonprofit corporation  
16 under a State law, or

17 “(II) which is described in section  
18 501(c)(4) of the Internal Revenue Code of  
19 1986 and the activities of which consist of  
20 providing commercial-type insurance (with-  
21 in the meaning of section 501(m) of such  
22 Code),

1           “(ii) the premium rate increases of  
2           which are regulated by a State authority,

3           “(iii) which, as of the date of the en-  
4           actment of this section, acts as the insurer  
5           of last resort in the State and is subject to  
6           State guarantee issue requirements, and

7           “(iv) for which the medical loss ratio  
8           (determined in a manner consistent with  
9           the determination of such ratio under sec-  
10          tion 2718(b)(1)(A) of the Public Health  
11          Service Act) with respect to the individual  
12          insurance market for such entity for the  
13          calendar year is not less than 100 percent,  
14          “(D) any entity—

15           “(i)(I) which is incorporated as a non-  
16           profit corporation under a State law, or

17           “(II) which is described in section  
18           501(e)(4) of the Internal Revenue Code of  
19           1986 and the activities of which consist of  
20           providing commercial-type insurance (with-  
21           in the meaning of section 501(m) of such  
22           Code), and

23           “(ii) for which the medical loss ratio  
24           (as so determined)—

1                   “(I) with respect to each of the  
2                   individual, small group, and large  
3                   group insurance markets for such en-  
4                   tity for the calendar year is not less  
5                   than 90 percent, and

6                   “(II) with respect to all such  
7                   markets for such entity for the cal-  
8                   endar year is not less than 92 per-  
9                   cent, or

10                  “(E) any entity—

11                   “(i) which is a mutual insurance com-  
12                  pany,

13                   “(ii) which for the period reported on  
14                  the 2008 Accident and Health Policy Ex-  
15                  perience Exhibit of the National Associa-  
16                  tion of Insurance Commissioners had—

17                   “(I) a market share of the in-  
18                  sured population of a State of at least  
19                  40 but not more than 60 percent, and

20                   “(II) with respect to all markets  
21                  described in subparagraph (D)(ii)(I),  
22                  a medical loss ratio of not less than  
23                  90 percent, and

24                   “(iii) with respect to annual payment  
25                  dates in calendar years after 2011, for

1           which the medical loss ratio (determined in  
2           a manner consistent with the determina-  
3           tion of such ratio under section  
4           2718(b)(1)(A) of the Public Health Service  
5           Act) with respect to all such markets for  
6           such entity for the preceding calendar year  
7           is not less than 89 percent (except that  
8           with respect to such annual payment date  
9           for 2012, the calculation under  
10          2718(b)(1)(B)(ii) of such Act is deter-  
11          mined by reference to the previous year,  
12          and with respect to such annual payment  
13          date for 2013, such calculation is deter-  
14          mined by reference to the average for the  
15          previous 2 years).”.

16          (d) CERTAIN INSURANCE EXEMPTED FROM FEE.—  
17          Paragraph (3) of section 9010(h) of this Act is amended  
18          to read as follows:

19                 “(3) HEALTH INSURANCE.—The term ‘health  
20          insurance’ shall not include—

21                         “(A) any insurance coverage described in  
22                         paragraph (1)(A) or (3) of section 9832(c) of  
23                         the Internal Revenue Code of 1986,

24                         “(B) any insurance for long-term care, or

1                   “(C) any medicare supplemental health in-  
2                   surance (as defined in section 1882(g)(1) of the  
3                   Social Security Act).”.

4           (e) ANTI-AVOIDANCE GUIDANCE.—Subsection (i) of  
5 section 9010 of this Act is amended by inserting “and  
6 shall prescribe such regulations as are necessary or appro-  
7 priate to prevent avoidance of the purposes of this section,  
8 including inappropriate actions taken to qualify as an ex-  
9 empt entity under subsection (c)(2)” after “section”.

10          (f) CONFORMING AMENDMENTS.—

11               (1) Section 9010(a)(1) of this Act is amended  
12               by striking “2009” and inserting “2010”.

13               (2) Section 9010(c)(2)(B) of this Act is amend-  
14               ed by striking “(except” and all that follows through  
15               “1323”.

16               (3) Section 9010(c)(3) of this Act is amended  
17               by adding at the end the following new sentence: “If  
18               any entity described in subparagraph (C)(i)(I),  
19               (D)(i)(I), or (E)(i) of paragraph (2) is treated as a  
20               covered entity by reason of the application of the  
21               preceding sentence, the net premiums written with  
22               respect to health insurance for any United States  
23               health risk of such entity shall not be taken into ac-  
24               count for purposes of this section.”.

1           (4) Section 9010(g)(1) of this Act is amended  
2           by striking “and third party administration agree-  
3           ment fees”.

4           (5) Section 9010(j) of this Act is amended—

5                   (A) by striking “2008” and inserting  
6                   “2009”, and

7                   (B) by striking “, and any third party ad-  
8                   ministration agreement fees received after such  
9                   date”.

10          (g) EFFECTIVE DATE.—The amendments made by  
11 this section shall take effect as if included in the enact-  
12 ment of section 9010.

13 **SEC. 10906. MODIFICATIONS TO ADDITIONAL HOSPITAL IN-**  
14 **SURANCE TAX ON HIGH-INCOME TAXPAYERS.**

15          (a) FICA.—Section 3101(b)(2) of the Internal Rev-  
16 enue Code of 1986, as added by section 9015(a)(1) of this  
17 Act, is amended by striking “0.5 percent” and inserting  
18 “0.9 percent”.

19          (b) SECA.—Section 1401(b)(2)(A) of the Internal  
20 Revenue Code of 1986, as added by section 9015(b)(1)  
21 of this Act, is amended by striking “0.5 percent” and in-  
22 serting “0.9 percent”.

23          (c) EFFECTIVE DATE.—The amendments made by  
24 this section shall apply with respect to remuneration re-

1 ceived, and taxable years beginning, after December 31,  
2 2012.

3 **SEC. 10907. EXCISE TAX ON INDOOR TANNING SERVICES IN**  
4 **LIEU OF ELECTIVE COSMETIC MEDICAL PRO-**  
5 **CEDURES.**

6 (a) IN GENERAL.—The provisions of, and amend-  
7 ments made by, section 9017 of this Act are hereby  
8 deemed null, void, and of no effect.

9 (b) EXCISE TAX ON INDOOR TANNING SERVICES.—  
10 Subtitle D of the Internal Revenue Code of 1986, as  
11 amended by this Act, is amended by adding at the end  
12 the following new chapter:

13 **“CHAPTER 49—COSMETIC SERVICES**

“Sec. 5000B. Imposition of tax on indoor tanning services.

14 **“SEC. 5000B. IMPOSITION OF TAX ON INDOOR TANNING**  
15 **SERVICES.**

16 “(a) IN GENERAL.—There is hereby imposed on any  
17 indoor tanning service a tax equal to 10 percent of the  
18 amount paid for such service (determined without regard  
19 to this section), whether paid by insurance or otherwise.

20 “(b) INDOOR TANNING SERVICE.—For purposes of  
21 this section—

22 “(1) IN GENERAL.—The term ‘indoor tanning  
23 service’ means a service employing any electronic  
24 product designed to incorporate 1 or more ultraviolet

1 lamps and intended for the irradiation of an indi-  
2 vidual by ultraviolet radiation, with wavelengths in  
3 air between 200 and 400 nanometers, to induce skin  
4 tanning.

5 “(2) EXCLUSION OF PHOTOTHERAPY SERV-  
6 ICES.—Such term does not include any phototherapy  
7 service performed by a licensed medical professional.

8 “(c) PAYMENT OF TAX.—

9 “(1) IN GENERAL.—The tax imposed by this  
10 section shall be paid by the individual on whom the  
11 service is performed.

12 “(2) COLLECTION.—Every person receiving a  
13 payment for services on which a tax is imposed  
14 under subsection (a) shall collect the amount of the  
15 tax from the individual on whom the service is per-  
16 formed and remit such tax quarterly to the Sec-  
17 retary at such time and in such manner as provided  
18 by the Secretary.

19 “(3) SECONDARY LIABILITY.—Where any tax  
20 imposed by subsection (a) is not paid at the time  
21 payments for indoor tanning services are made, then  
22 to the extent that such tax is not collected, such tax  
23 shall be paid by the person who performs the serv-  
24 ice.”.

1 (c) CLERICAL AMENDMENT.—The table of chapter  
2 for subtitle D of the Internal Revenue Code of 1986, as  
3 amended by this Act, is amended by inserting after the  
4 item relating to chapter 48 the following new item:

“CHAPTER 49—COSMETIC SERVICES”.

5 (d) EFFECTIVE DATE.—The amendments made by  
6 this section shall apply to services performed on or after  
7 July 1, 2010.

8 **SEC. 10908. EXCLUSION FOR ASSISTANCE PROVIDED TO**  
9 **PARTICIPANTS IN STATE STUDENT LOAN RE-**  
10 **PAYMENT PROGRAMS FOR CERTAIN HEALTH**  
11 **PROFESSIONALS.**

12 (a) IN GENERAL.—Paragraph (4) of section 108(f)  
13 of the Internal Revenue Code of 1986 is amended to read  
14 as follows:

15 “(4) PAYMENTS UNDER NATIONAL HEALTH  
16 SERVICE CORPS LOAN REPAYMENT PROGRAM AND  
17 CERTAIN STATE LOAN REPAYMENT PROGRAMS.—In  
18 the case of an individual, gross income shall not in-  
19 clude any amount received under section 338B(g) of  
20 the Public Health Service Act, under a State pro-  
21 gram described in section 338I of such Act, or under  
22 any other State loan repayment or loan forgiveness  
23 program that is intended to provide for the in-  
24 creased availability of health care services in under-

1 served or health professional shortage areas (as de-  
2 termined by such State).”.

3 (b) **EFFECTIVE DATE.**—The amendment made by  
4 this section shall apply to amounts received by an indi-  
5 vidual in taxable years beginning after December 31,  
6 2008.

7 **SEC. 10909. EXPANSION OF ADOPTION CREDIT AND ADOP-**  
8 **TION ASSISTANCE PROGRAMS.**

9 (a) **INCREASE IN DOLLAR LIMITATION.**—

10 (1) **ADOPTION CREDIT.**—

11 (A) **IN GENERAL.**—Paragraph (1) of sec-  
12 tion 23(b) of the Internal Revenue Code of  
13 1986 (relating to dollar limitation) is amended  
14 by striking “\$10,000” and inserting “\$13,170”.

15 (B) **CHILD WITH SPECIAL NEEDS.**—Para-  
16 graph (3) of section 23(a) of such Code (relat-  
17 ing to \$10,000 credit for adoption of child with  
18 special needs regardless of expenses) is amend-  
19 ed—

20 (i) in the text by striking “\$10,000”  
21 and inserting “\$13,170”, and

22 (ii) in the heading by striking  
23 “\$10,000” and inserting “\$13,170”.

24 (C) **CONFORMING AMENDMENT TO INFLA-**  
25 **TION ADJUSTMENT.**—Subsection (h) of section

1           23 of such Code (relating to adjustments for in-  
2           flation) is amended to read as follows:

3           “(h) ADJUSTMENTS FOR INFLATION.—

4           “(1) DOLLAR LIMITATIONS.—In the case of a  
5           taxable year beginning after December 31, 2010,  
6           each of the dollar amounts in subsections (a)(3) and  
7           (b)(1) shall be increased by an amount equal to—

8                   “(A) such dollar amount, multiplied by

9                   “(B) the cost-of-living adjustment deter-  
10                  mined under section 1(f)(3) for the calendar  
11                  year in which the taxable year begins, deter-  
12                  mined by substituting ‘calendar year 2009’ for  
13                  ‘calendar year 1992’ in subparagraph (B)  
14                  thereof.

15           If any amount as increased under the preceding sen-  
16           tence is not a multiple of \$10, such amount shall be  
17           rounded to the nearest multiple of \$10.

18           “(2) INCOME LIMITATION.—In the case of a  
19           taxable year beginning after December 31, 2002, the  
20           dollar amount in subsection (b)(2)(A)(i) shall be in-  
21           creased by an amount equal to—

22                   “(A) such dollar amount, multiplied by

23                   “(B) the cost-of-living adjustment deter-  
24                  mined under section 1(f)(3) for the calendar  
25                  year in which the taxable year begins, deter-

1           mined by substituting ‘calendar year 2001’ for  
2           ‘calendar year 1992’ in subparagraph (B)  
3           thereof.

4           If any amount as increased under the preceding sen-  
5           tence is not a multiple of \$10, such amount shall be  
6           rounded to the nearest multiple of \$10.”.

7           (2) ADOPTION ASSISTANCE PROGRAMS.—

8           (A) IN GENERAL.—Paragraph (1) of sec-  
9           tion 137(b) of the Internal Revenue Code of  
10          1986 (relating to dollar limitation) is amended  
11          by striking “\$10,000” and inserting “\$13,170”.

12          (B) CHILD WITH SPECIAL NEEDS.—Para-  
13          graph (2) of section 137(a) of such Code (relat-  
14          ing to \$10,000 exclusion for adoption of child  
15          with special needs regardless of expenses) is  
16          amended—

17                  (i) in the text by striking “\$10,000”  
18                  and inserting “\$13,170”, and

19                  (ii) in the heading by striking  
20                  “\$10,000” and inserting “\$13,170”.

21          (C) CONFORMING AMENDMENT TO INFLA-  
22          TION ADJUSTMENT.—Subsection (f) of section  
23          137 of such Code (relating to adjustments for  
24          inflation) is amended to read as follows:

25          “(f) ADJUSTMENTS FOR INFLATION.—

1           “(1) DOLLAR LIMITATIONS.—In the case of a  
2 taxable year beginning after December 31, 2010,  
3 each of the dollar amounts in subsections (a)(2) and  
4 (b)(1) shall be increased by an amount equal to—

5                   “(A) such dollar amount, multiplied by

6                   “(B) the cost-of-living adjustment deter-  
7 mined under section 1(f)(3) for the calendar  
8 year in which the taxable year begins, deter-  
9 mined by substituting ‘calendar year 2009’ for  
10 ‘calendar year 1992’ in subparagraph (B)  
11 thereof.

12           If any amount as increased under the preceding sen-  
13 tence is not a multiple of \$10, such amount shall be  
14 rounded to the nearest multiple of \$10.

15           “(2) INCOME LIMITATION.—In the case of a  
16 taxable year beginning after December 31, 2002, the  
17 dollar amount in subsection (b)(2)(A) shall be in-  
18 creased by an amount equal to—

19                   “(A) such dollar amount, multiplied by

20                   “(B) the cost-of-living adjustment deter-  
21 mined under section 1(f)(3) for the calendar  
22 year in which the taxable year begins, deter-  
23 mined by substituting ‘calendar year 2001’ for  
24 ‘calendar year 1992’ in subparagraph thereof.

1 If any amount as increased under the preceding sen-  
2 tence is not a multiple of \$10, such amount shall be  
3 rounded to the nearest multiple of \$10.”.

4 (b) CREDIT MADE REFUNDABLE.—

5 (1) CREDIT MOVED TO SUBPART RELATING TO  
6 REFUNDABLE CREDITS.—The Internal Revenue  
7 Code of 1986 is amended—

8 (A) by redesignating section 23, as amend-  
9 ed by subsection (a), as section 36C, and

10 (B) by moving section 36C (as so redesign-  
11 nated) from subpart A of part IV of subchapter  
12 A of chapter 1 to the location immediately be-  
13 fore section 37 in subpart C of part IV of sub-  
14 chapter A of chapter 1.

15 (2) CONFORMING AMENDMENTS.—

16 (A) Section 24(b)(3)(B) of such Code is  
17 amended by striking “23,”.

18 (B) Section 25(e)(1)(C) of such Code is  
19 amended by striking “23,” both places it ap-  
20 pears.

21 (C) Section 25A(i)(5)(B) of such Code is  
22 amended by striking “23, 25D,” and inserting  
23 “25D”.

24 (D) Section 25B(g)(2) of such Code is  
25 amended by striking “23,”.

1           (E) Section 26(a)(1) of such Code is  
2 amended by striking “23,”.

3           (F) Section 30(c)(2)(B)(ii) of such Code is  
4 amended by striking “23, 25D,” and inserting  
5 “25D”.

6           (G) Section 30B(g)(2)(B)(ii) of such Code  
7 is amended by striking “23,”.

8           (H) Section 30D(c)(2)(B)(ii) of such Code  
9 is amended by striking “sections 23 and” and  
10 inserting “section”.

11           (I) Section 36C of such Code, as so reded-  
12 igned, is amended—

13               (i) by striking paragraph (4) of sub-  
14 section (b), and

15               (ii) by striking subsection (c).

16           (J) Section 137 of such Code is amend-  
17 ed—

18               (i) by striking “section 23(d)” in sub-  
19 section (d) and inserting “section 36C(d)”,  
20 and

21               (ii) by striking “section 23” in sub-  
22 section (e) and inserting “section 36C”.

23           (K) Section 904(i) of such Code is amend-  
24 ed by striking “23,”.

1           (L) Section 1016(a)(26) is amended by  
2 striking “23(g)” and inserting “36C(g)”.

3           (M) Section 1400C(d) of such Code is  
4 amended by striking “23,”.

5           (N) Section 6211(b)(4)(A) of such Code is  
6 amended by inserting “36C,” before “53(e)”.

7           (O) The table of sections for subpart A of  
8 part IV of subchapter A of chapter 1 of such  
9 Code of 1986 is amended by striking the item  
10 relating to section 23.

11           (P) Paragraph (2) of section 1324(b) of  
12 title 31, United States Code, as amended by  
13 this Act, is amended by inserting “36C,” after  
14 “36B,”.

15           (Q) The table of sections for subpart C of  
16 part IV of subchapter A of chapter 1 of the In-  
17 ternal Revenue Code of 1986, as amended by  
18 this Act, is amended by inserting after the item  
19 relating to section 36B the following new item:

“Sec. 36C. Adoption expenses.”.

20           (c) APPLICATION AND EXTENSION OF EGTRRA  
21 SUNSET.—Notwithstanding section 901 of the Economic  
22 Growth and Tax Relief Reconciliation Act of 2001, such  
23 section shall apply to the amendments made by this sec-  
24 tion and the amendments made by section 202 of such

1 Act by substituting “December 31, 2011” for “December  
2 31, 2010” in subsection (a)(1) thereof.

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